

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02016306

## 1. PLACE OF DEATH:

County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 daysHospital, institution, or street address where death occurred Fletcher HospitalHow long in hospital or institution? 54 days

## 3. (a) FULL NAME

Nellie Regina Ambrose

## 3. (b) Social Security Number

214-09-0483

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife George Ambrose

7. Birth date of

deceased (mo., day, yr.)

March 3 1876

8. AGE:

Years

72

Months

11

Days

19

If less than one day

hrs.

min.

9. Birthplace

Hagerstown, Wash., Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

12. Name

J. E. Gaus

13. Birthplace

Hagerstown, Md.

14. Maiden name

Sarah H. Brill

15. Birthplace

Fayetteville Pa.

16. Informant

Mrs. John F. Lewis

Address

Hagerstown Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 3/24/48

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.19. Feb. 24. 48

(Date rec'd by registrar)

Registrar

Per W. Ferguson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Washington

City or town

Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

15 1/2 Mulberry  
(If rural, give LOCATION)

2. (a) If veteran, name war

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 2219. 48at 4:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 3019. 47to Feb. 2219. 48and that I last saw her alive on Feb. 2219. 48

Immediate cause of death

Respiratory failure

Due to

Chronic bronchitis

Due to

Cardiac decompensation

Other conditions

Terminal bronchopneumoniaQuestion of mediastinal mass?  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas M. Cuyington M.D.

M. D. or other

Address

Fletcher Hospital

Date signed

2/22/48Cascade, Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Yeager

02017

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
235 South Locust St.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 235 South Locust St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

CHARLES BENJAMIN ARTHUR

## 3. (b) Social Security Number

219-05-2053

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Frances Viola  
 6.(c) If alive, give age 77 years  
 7. Birth date of deceased (mo., day, yr.) March 26, 1871  
 8. AGE: Years 76 Months 9 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Thurmont, Fredrick Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Clerk Retired  
 11. Industry or business H. L. Mills

FATHER 12. Name Hiram Arthur  
 13. Birthplace Thurmont Md.  
 MOTHER 14. Maiden name Nancy Heine  
 15. Birthplace Thurmont Md.

16. Informant Chester C. Arthur  
 Address Hagerstown, Md.

17. Burial Date thereof 2/13/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb. 11. 1948 Chas H Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948 at 10:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7, 1948 to Feb 9, 1948  
 and that I last saw him alive on Feb 9, 1948

Immediate cause of death Cerebral hemorrhage DURATION 6 hours

Due to \_\_\_\_\_

Due to arteriosclerosis Neg + + +

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

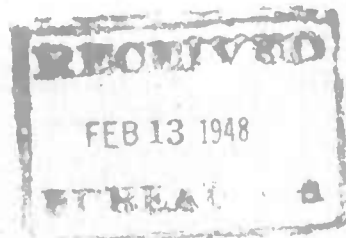
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur X X X X  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. Howard Yeager M. D. 2-10-48  
 Address Hagerstown Md. Date signed \_\_\_\_\_





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02018 304

1. PLACE OF DEATH:  
County..... Washington  
City or town..... Hancock  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... Life  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Washington  
City or town..... Hancock  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Charles Henry Baker

### 3. (b) Social Security Number

4. Sex..... Male  
5. Color or race..... Negro  
6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Nettie P. Baker

7. Birth date of deceased (mo., day, yr.)..... June 18, 1875  
8. (c) If alive, give age..... years

8. AGE: Years..... 72 yrs. Months..... 8 Days..... 29  
If less than one day..... hrs. .... min.

9. Birthplace..... Martinsburg, W. Va.  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... Unknown

13. Birthplace.....

14. Maiden name..... Anna Green

15. Birthplace..... Martinsburg, W. Va.

16. Informant..... Mrs. Lillian Hall

Address..... Hancock, Maryland

17. Burial.....  
(Burial, cremation, or removal. Which?) Date thereof..... Feb 22, 1948  
(month) (day) (year)

Cemetery or crematory..... Woodlawn Cemetery

Location..... Cumberland, Md.

18. Funeral director..... Snyder-Rowland

Address..... Hancock, Md.

19. 2/21/48  
(Date rec'd by registrar) Registrar..... J. An. Helles

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 19 19..... 48 at..... 4:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
and that I last saw him alive on.....  
.....

Immediate cause of death..... DURATION.....

Chronic myocarditis

Due to..... Chronic nephritis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... B. M. Shaffer M.D.  
Address..... Hancock, Md. Date signed..... 2/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **302**

### 1. PLACE OF DEATH:

County..... **Washington**  
City or town..... **Hagerstown**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **1 month 6 days**  
Hospital, institution, or street address where death occurred:  
**Washington County Hospital**  
How long in hospital or institution? **1 month 6 days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... **Md.** County..... **Wash.**  
City or town..... **Hagerstown**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... **802 W. Franklin St.**  
(If rural, give LOCATION)  
2.(a) If veteran, name War.....

### 3. (a) FULL NAME

**Sheila Teresa Bent**

### 3. (b) Social Security Number

4. Sex..... **female**  
5. Color or race..... **white**  
6.(a) Single, married, widowed, or divorced.....  
6.(b) Name of husband or wife.....  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... **January 5, 1948**  
8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.  
**1 6**

9. Birthplace..... **Hagerstown, Wash. Co., Md.**  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... **Herbert L. Bent**  
13. Birthplace..... **McCook, Nebraska**

MOTHER 14. Maiden name..... **Ethel M. Van Gosen**  
15. Birthplace..... **Berekley Springs, W.Va.**

16. Informant..... **Herbert L. Bent**  
Address..... **Hagerstown, Md.**

17. **burial** Date thereof..... **2-13-48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... **Rest Haven Cemetery**  
Location..... **Hagerstown, Md.**

18. Funeral director..... **Scott F. Minnich & Son**  
Address..... **Hagerstown, Md.**

19. **Feb. 12, 1948**  
(Date rec'd by registrar) Registrar.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Feb. 11, 1948** at **6:58 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **January 5, 1948** to **Feb 4, 1948** and that I last saw him alive on **Feb 11, 1948**

Immediate cause of death..... **Malnutrition**

Due to..... **Infectious diarrhea**

Due to..... **Staphylococcus aureus enteritis**

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?

23. SIGNATURE..... **Elizabeth L. Lavin**  
M. D. or other

Address..... **214 N. Potomac St. Hagerstown, Md.** Date signed..... **2-22-48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and completely. is especially important. Physicians: please write the causes of death clearly and completely.

RECEIVED

FEB 14 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02020

304

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural - Hancock  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No. —  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Millard Fillmore Bishop

## 3. (b) Social Security Number

212-14-6046

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Annie Belle Munson

7. Birth date of

deceased (mo., day, yr.)

Sept. 4, 18788. (c) If alive, give age — years

8. AGE:

Years

Months

Days

If less than one day

69513— hrs.— min.

9. Birthplace

Washington Co., Md.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

George A. Bishop

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Rebecca Welsh

15. Birthplace

Pennsylvania

16. Informant

Mr. J. F. Brooks

Address

Route #1, Hancock, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 21, 1948  
(month) (day) (year)

Cemetery or crematory

Mt. Olivet Presbyterian

Location

Route 40 - west of Hancock

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19.

(Date rec'd by registrar)

2/21/48

19.

John H. Heller

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 17, 1948 at last M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 17, 1948 to Feb 17, 1948  
and that I last saw him alive on Feb 17, 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

inferior pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. Shaffer MD

M. D. or other

Address

Hancock, Md.Date signed 2/20/48

**RECEIVED**

FEB 25 1948

**BUREAU V. S.**

Evidence for the change of  
age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02021

FHM No. G 114 FEB 19 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? less than 1 hour

Hospital, institution, or street address where death occurred:

145 Alexander St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 376 Cleveland Ave., South  
(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3.(a) FULL NAME

Wilbur Roscoe Bishop

## 3.(b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6.(a) Single, married, or divorced

Divorced

8.(b) Name of husband or wife ex-wife, Now Anna Jackson

8.(c) If alive, give age 39 years

7. Birth date of  
deceased (mo., day, yr.) June 10, 1890

8. AGE:

Years

Months

Days

If less than one day

61 57

8

0

hrs.

min.

9. Birthplace Johnstown, Pa.  
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name Mr. Bishop

13. Birthplace Near Hancock, Md.

14. Maiden name Anna Miller

15. Birthplace Bedford Co., Pa.

16. Informant Mrs. Anna E. Dittmer

Address 145 Alexander St.

17. Burial  
(Burial, cremation, or removal, Which?)

Date thereof 2/13/48  
(month) (day) (year)

Cemetery or crematory Bonsboro Cemetery

Location Bonsboro Md.

18. Funeral director W. J. Norment

Address Hagerstown Md.

19. Feb 12, 1948 Chas. H. Hovens  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 February 19 48, at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on 10 Feb. 19 48, to 19

and that I last saw him alive on 10 February 19 48

Immediate cause of death Pulmonary edema

DURATION

2-3

hours

Due to Cardiac failure

Due to Arteriosclerotic heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Antopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Robert F. Keadle  
M. D. or other

Address 132 W. Wash St. Date signed 2-10-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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FEB 14 1948

SECRET

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02022

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life Resident  
Hospital, institution, or street address where death occurred:  
646 N. prospect Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 646 N. Prospect St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

Anna Amelia Bonebrake

### 3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Charles C. Bonebrake

7. Birth date of deceased (mo., day, yr.) November 10, 1885 6.(c) If alive, give age 1-1-45 years

8. AGE: Years 62 Months 2 Days 22 If less than one day hrs. min.

9. Birthplace Washington County, Md.  
(Town, county, and state)

10. Usual occupation Home Duties

### 11. Industry or business

12. Name Bachtel

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Charles Bonebrake

Address 646 N. Prospect Street- Hagerstown, Md.

17. Burial Feb. 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rpse Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Feb. 4, 48 (Date rec'd by registrar) Registrar Charles H. Bowers

### MEDICAL CERTIFICATION

2D. DATE OF DEATH February 1, 1948 10:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-45 19 to 2-1-48 19 and that I last saw her alive on 1-26-48 19

Immediate cause of death

Cerebral Hemorrhage  
Due to Chronic Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Charles H. Bowers M. D. or other Physician  
Address Hagerstown, Md. Date signed Feb. 4, 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED

RECEIVED  
FEB 6 1948  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02023

1. PLACE OF DEATH: WASHINGTON  
HAGERSTOWN  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
42 N MULBERRY ST.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
Md. County WASHINGTON  
HAGERSTOWN  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
42 N. MULBERRY ST.  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME MRS. MARY COOK BOWERS 3. (b) Social Security Number

4. Sex Fem. 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) Apr. 10, 1866 8. (c) If alive, give age..... years  
 8. AGE: Years 81 Months 8 Days 24 If less than one day..... hrs. .... min.

9. Birthplace FRANKLIN Co. PA.  
 (Town, county, and state)  
 10. Usual occupation HOUSE KEEPER  
 11. Industry or business JOHN C. COOK  
 12. Name FRANKLIN Co. PA.  
 13. Birthplace ELIZABETH HELSER  
 14. Maiden name WASHINGTON Co., Md.  
 15. Birthplace Mrs. C. C. GLAZER  
 16. Informant MERCERSBURG, PENNA.  
 Address

17. BURIAL Date thereof 2/7/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Union Cem.  
 Location Franklin Co. Mercersburg, B. P. 3  
Th. Lininger  
 18. Funeral director Mercersburg, Pa.  
 Address  
 19. Feb. 4, 48 W. Howard George  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
 20. DATE OF DEATH Feb. 4 19 48 at 5:30 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4 19 47 to Feb. 4 19 48  
 and that I last saw him alive on Feb. 3 19 48  
 Immediate cause of death Carcinomatous  
Primary carcinoma  
Right Mammary  
4 yrs  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Radical Mastectomy  
Chemo (Mammary) Date of op. ....  
 Autopsy results NO  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE W. Howard George  
Hagerstown Md.  
 Address..... M. D. or other  
 Date signed 2-4-48

RECEIVED  
FEB 6 1948  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural - Hagerstown, Md. R D 5  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Leitersburg Pike

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Rural Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Leitersburg Pike  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Keller C. Bowman

## 3.(b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Alta M. Bowman7. Birth date of deceased (mo., day, yr.) July 12, 1890

6.(c) If alive, give age years

## 8. AGE:

Years

57

Months

7

Days

4

If less than one day

hrs.

min.

9. Birthplace Franklin County, Pa.

(Town, county, and state)

10. Usual occupation Farming

## 11. Industry or business

12. Name David Bowman13. Birthplace Washington County, Md.14. Maiden name Maria Lowman15. Birthplace Washington County, Md.16. Informant Mrs. Alta M. BowmanAddress Hagerstown, Md. R D 517. Burial Date thereof Feb. 18, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Leitersburg, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Feb. 18, 1948 Charles Powers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1948 6:50 A. 19. 48 at 19 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 - 1948 to Feb 16 1948 and that I last saw him alive on Feb 15 1948

Immediate cause of death

chronic arthritis  
chronic endocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

V. H. D. Miller

M. D. or

Address Date signed Feb 17 1948

RECEIVED

FEB 20 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02025

92a

J03

## 1. PLACE OF DEATH:

County Washington  
 City or town Wilson, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
Gateway Nursing Home  
 How long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 909 Hamilton Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary E. Brewer

## 3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Edward Brewer 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 26, 1862  
 8. AGE: Years 85 Months 2 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Four Lock, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business

MOTHER FATHER  
 12. Name Louis Fernsner  
 13. Birthplace Not Known  
 14. Maiden name Martha Silver  
 15. Birthplace Virginia

18. Informant Wayne Fernsner  
 Address Hagerstown, Maryland  
 17. Burial Burial Date thereof 2-7-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Paul Cemetery  
 Location Western Pike, Maryland  
 18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland  
 19. 2-6-48 19. 2-6-48  
 (Date rec'd by registrar) (Date signed by registrar)

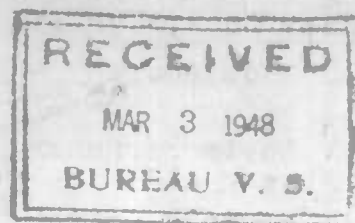
## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 - 1948 at 2:30 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1948 to Feb 5 - 1948  
 and that I last saw her alive on Feb 2nd at 10:48  
 Immediate cause of death Chronic Endocarditis  
arterio-sclerosis. DURATION \_\_\_\_\_  
 Due to 2 - \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations 3 \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results 0 \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide None Date of \_\_\_\_\_  
 Where did injury occur? None (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury None Injured at work? \_\_\_\_\_  
 Signature Victor D. Miller  
DR. VICTOR D. MILLER  
 131 W. WASHINGTON, ST.  
 Address \_\_\_\_\_ Date signed 2/6 - 1948

See letter under Dr. Miller stating that no injury was involved, dated  
April 1, 1946.

as.  
4/6/46



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

### 1. PLACE OF DEATH:

County Washington  
City or town Rural R.F.D.1. Williamsport MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 Years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Rural R.F.D.1. Williamsport.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

William George Brillhart

### 3. (b) Social Security Number

None.

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Iva M Brillhart

7. Birth date of deceased (mo., day, yr.) Month & day unknown 1874 Yr. 6.(c) If alive, give age 32 years

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Williamsport Washington MD.  
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business Farmer.

12. Name John Brillhart

13. Birthplace Williamsport M.D.

14. Maiden name Sarah Jane Potts

15. Birthplace Williamsport M.D.

16. Informant Mrs. Iva Brillhart  
Address Williamsport R.F.D. I.

17. Burial Date thereof Feb. 18 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory ST. Pauls .US.40  
Location Near Clearspring MD.

18. Funeral director Edith V Leaf  
Address Williamsport MD.

19. 2/17 48 Mrs. E. Lee M. Chon  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/48 19\_\_\_\_ at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/14/48 19\_\_\_\_

and that I last saw him alive on 2/14/48 19\_\_\_\_

Immediate cause of death Cerebral Occlusion

DURATION

1 Day

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. L. Granger M.D. or other \_\_\_\_\_  
Address Williamsport Md. Date signed 2/16/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of age  
is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02027

FILM No. G 114 MAR 9 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington

City or town Williamsport  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 years

Hospital, institution, or street address where death occurred:

14 West Salisbury St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 West Salisbury St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Annie Mary Byers

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Simon Byers

Deceased

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1885

8. AGE:

62 ~~65~~

Years

Months

11

Days

10

If less than one day

hrs. min.

9. Birthplace Williamsport, Washington, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

At Home

11. Industry or business

12. Name John Hawbaker

13. Birthplace Wilson, Maryland

14. Maiden name Sarah Van Dray

15. Birthplace Wilson, Maryland

16. Informant Mrs. Clyde Miller Md.

Address 14 W. Salisbury St., Williamsport

17. Burial Date thereof March 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Cemetery.

Location Williamsport, Maryland.

Mrs. Edith V. Leaf

18. Funeral director Williamsport, Maryland.

Address Williamsport, Maryland.

19. 3/1 19 48 Mrs. E. Lee McElroy  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/48 19 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/25/48 19 2/28/48 19

and that I last saw him alive on 2/28/48 19

Immediate cause of death Coronary Occlusion DURATION

Immediate

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE R. F. Young

M. D. or other

Address Williamsport, Md. Date signed 2/28/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *203*

## 1. PLACE OF DEATH:-

County *Washington*  
 City or town *Bethesda - Aror. Wilman*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *5 wks.*  
 Hospital, institution, or street address where death occurred:

*Gate way Nursing Home*  
 How long in hospital or institution? *5 wks.*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Pa.* County *Franklin*  
 City or town *Bethesda*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *Fayetteville #5*  
 (If rural, give LOCATION) ✓

2. (a) If veteran, name war.

## 3. (a) FULL NAME

*Hiram L. Corbaugh*

## 3. (b) Social Security Number

## 4. Sex

*male*

## 5. Color or race

*white*

## 6. (a) Single, married, widowed, or divorced

*widowed*6. (b) Name of husband or wife *Edna Faye*

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) *Sept 8 1888*

## 8. AGE:

Years

Months

Days

If less than one day

*67**5**12*

hrs.

min.

9. Birthplace *Fayetteville #5 Pa.*

(Town, county, and state)

10. Usual occupation *mechanic*

## 11. Industry or business

12. Name *Albert Corbaugh*13. Birthplace *Fayetteville #5 Pa.*14. Maiden name *Nancy Strong*15. Birthplace *Fayetteville #5 Pa.*16. Informant *Mrs. H. Emma Carl*Address *Williamsport Md.*17. *Burial* Date thereof *2/23/48*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory *Strong's Grave yard*Location *Fayetteville #5 Pa.*18. Funeral director *Watts & Sons*Address *271. Church St. Waynesboro, Pa.*

19. *Feb 20. 48* Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 20 1948* at *6:15 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb. 1 1948* to *Feb. 20 1948* and that I last saw him alive on *Feb. 9 48*

Immediate cause of death

DURATION

*Cerebral hemorrhage**2 mos.*

Due to

*Arterio Sclerosis**2 mos.*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *no* Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address *Williamsport Md.* Date signed *2/20/48*



RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 months

Hospital, institution, or street address where death occurred:

916 St. Claire St.How long in hospital or institution? -6-

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County BerkleyCity or town Martinsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 407 Faulkner Ave.  
(If rural, give LOCATION)2.(c) If veteran, name war --- ✓

## 3. (a) FULL NAME

NETTIE FINNELL CLARK

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John William Clark

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

November 21, 1860

8. AGE:

Years

Months

Days

If less than one day

8730

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

9. Birthplace Whitehall, Virginia

(Town, county, and state)

10. Usual occupation housewife11. Industry or business homeFATHER 12. Name John Finnell13. Birthplace Flint Hill, VaMOTHER 14. Maiden name Nancy Settle15. Birthplace Flint Hill, Va.16. Informant Sgt. H. A. AlbeñadoAddress Quantico, Va.17. removal

(Burial, cremation, or removal. Which?)

Date thereof Feb 21, 1948  
(month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Martinsburg, W. Va.18. Funeral director Scott F. Minnich & SonAddress Hagerstown, Md.19. Feb. 21, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1948 11:23 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13 1948 to date of death 1948and that I last saw him/her alive on February 20 1948Immediate cause of death Pneumonia, lobar (left lower) Renal failure (right) DURATION 3 daysDue to Arteriosclerotic heart disease ?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations None done Date of op. \_\_\_\_\_Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert T. Headle M. D. 2-21-48Address 132 W. Wash St. Date signed 2-21-48

RECEIVED

FEB 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Washington andCity or town Leavetown and

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 4 mosHospital, institution, or street address where death occurred: —How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Leavetown and

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

Silas. Watta. Coline

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife none6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) 2-1-1908

## 8. AGE:

Years

Months

Days

If less than one day

79712— hrs. — min.9. Birthplace Near Leavetown and

(Town, county, and state)

10. Usual occupation Trucker11. Industry or business —

## FATHER

12. Name John Coline13. Birthplace Near Smithsburg and

## MOTHER

14. Maiden name Susie L. Hoover15. Birthplace Poundsville and16. Informant Robert W. ColineAddress Leavetown and

## 17.

(Burial, cremation, or removal, which?) BurialDate thereof 2-16-1948

(month) (day) (year)

Cemetery or crematory Leavetown andLocation Leavetown and18. Funeral director Geo B. HooverAddress Smithsburg and

## 19.

(Date rec'd by registrar) Feb 13 1948Geo W. Hoover  
Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1948, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 9 1948 to Feb 13 1948and that I last saw him alive on Feb 13 1948

## Immediate cause of death

Cerebral hemorrhage

## DURATION

4 daysDue to arterio-sclerosis7 yrsDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? —

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE G. G. K. O'Leary

M. D. or other

Address Smithsburg Date signed 2/13/48

RECEIVED

FEB 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02031

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Rural Clear Spring, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life Resident  
 Hospital, institution, or street address where death occurred:  
Williamsport Road  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Washington  
 City or town..... Rural Clear Spring, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Williamsport Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

CHARLES E. COWTON

## 3. (b) Social Security Number

None

4. Sex..... Male  
 5. Color or race..... White  
 6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Anna A.

7. Birth date of deceased (mo., day, yr.)..... March 26, 1868  
 8. (c) If alive, give age..... years

8. AGE: Years..... 79 Months..... 10 Days..... 17  
 If less than one day..... hrs. .... min.

9. Birthplace..... Washington County, Md.  
(Town, county, and state)10. Usual occupation..... Farmer

11. Industry or business.....

12. Name..... Denton Cowton13. Birthplace..... Washington County, Md.14. Maiden name..... Margaret -----15. Birthplace..... Washington County, Md.16. Informant..... Jacob Ankeney,Address..... Clear Spring, Md.

17. Burial..... Date thereof..... Feb. 14, 1948  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Rose Hill CemeteryLocation..... Clear Spring, Md.18. Funeral director..... Snyder-Rowland Funeral HomeAddress..... Clear Spring, Md.

19. Feb 12 19 48 Joseph W. Murray  
 (Date rec'd by registrar)..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 12, 19 48..... 2:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan. 15, 19 48, to Feb. 12, 19 48  
 and that I last saw him alive on Feb. 11, 19 48

Immediate cause of death..... Chronic Endocarditis  
with Acute Cardiac  
Failure  
 Due to.....

Arterio Sclerosis  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

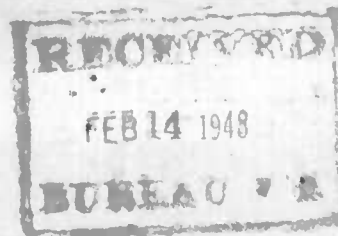
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... David P. Bruen M.D.  
 Address..... Clear Spring Md. M. D. or other  
 Date signed..... 2/12/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02038 305

## 1. PLACE OF DEATH

County WashingtonCity or town Fairplay  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred Fairplay md.How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Fairplay  
(If outside city or town limits, write RURAL and give nearest town)Street No. Fairplay md.  
(If rural, give LOCATION)2.(a) If veteran, name war World War one

## 3. (a) FULL NAME

James W. Davis

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Mrs Pearl Davis6.(c) If alive, give age 50 years

7. Birth date of

deceased (mo., day, yr.)

Sept 24 - 1889

8. AGE:

Years

Months

Days

If less than one day

58422

hrs.

min.

9. Birthplace

Doumarville Wash. Co. md.  
(Town, county, and state)

10. Usual occupation

Retired School Bus Operator

11. Industry or business

MOTHER FATHER

12. Name

Cornelius Davis

13. Birthplace

Doumarville Wash. Co. md.

14. Maiden name

Kate Davis

15. Birthplace

Doumarville Wash. Co. md.

16. Informant

Mrs. Pearl Davis

Address

Fairplay md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Feb. 19, 1948  
(month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown md.

18. Funeral director

Wm. J. Best & Son

Address

Boonsboro md.

19.

Feb. 18, 1948  
(Date rec'd by registrar)John H. Best  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 - 48 19... at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 - 48 19... to Feb 16 - 48 19...and that I last saw him alive on Feb 15 - 48 19...

Immediate cause of death

Pulmonary T. TB.

DURATION

1 1/2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. W. Best

M. D. or other

Address Hagerstown md. Date signed 2/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington

City or town... Finksburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:  
Baltimore Street

How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Finksburg  
(If outside city or town limits, write RURAL and give nearest town)Street No... Baltimore Street  
(If rural, give LOCATION)

2.(a) If veteran, name war... no

## 3.(a) FULL NAME

Florence Elizabeth Dinkle

## 3.(b) Social Security Number

none

4. Sex... Female

5. Color or race... white

6.(a) Single, married, widowed, or divorced... widowed

6.(b) Name of husband or wife... Charles Dinkle

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)... July - 11 - 1875

8. AGE: Years... 72 Months... 6 Days... 24

8. AGE: Years... 72 Months... 6 Days... 24

8. AGE: Years... 72 Months... 6 Days... 24

8. AGE: Years... 72 Months... 6 Days... 24

8. AGE: Years... 72 Months... 6 Days... 24

9. Birthplace... Md. New Wash. Co. Md.

(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... Own Home

12. Name... David Borman

13. Birthplace... Wash. Co. Md.

14. Maiden name... Louisa Fauders

15. Birthplace... Wash. Co. Md.

16. Informant... Miss Thelma Dinkle

Address... Finksburg Md.

17. Burial - Date thereof... Feb. 8, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Finksburg Cemetery

Location... near Mapleville Wash. Co. Md.

18. Funeral director... Wm B. Best &amp; Son

Address... Boonville Md.

19. Feb 6, 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... February - 5 - 1948 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20 1948 to Feb 5 1948

and that I last saw her alive on Feb 5 1948

Immediate cause of death... Coronary Thrombosis

## DURATION

11/27/48

Due to... Myocardial Infarction

Due to... Myocardial Infarction

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury... Injured at work?

23. SIGNATURE... Sidney Novak

M. D. or other

Address... Finksburg Md.

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

Date signed... 2/6/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02033

93d



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

### 1. PLACE OF DEATH:

County Wash.  
City or town Clear Spring Md.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Rural 1  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) Life time

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.  
City or town Clear Spring Md. Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. Dry Run R01  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Oliver James Ditto

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

### 6. (b) Name of husband or wife

6(c) If alive, give age 1870 years

7. Birth date of deceased (mo., day, yr.) Aug. 20 1870  
8. AGE: Years 77 Months 6 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wash Co. Md.  
(Town, county, and state)

10. Usual occupation Farmer Retired

### 11. Industry or business

12. Name Joshua Ditto

13. Birthplace Wash Co. Md.

14. Maiden name Martha Stite

15. Birthplace Wash Co. Md.

16. Informant Miriam Ditto

Address Clear Spring Md R01

17. Mercersburg Pa. Date thereon Feb. 25-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Fair View Cemetery Mercersburg Pa.

Location Mercersburg Pa

18. Funeral director D. J. Fininger & Son

Address Mercersburg Pa.

19. Feb 23 48 Rephew Murray  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1948 at 59 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28, 1947 to Feb 22, 1948  
and that I last saw him alive on Feb. 20, 1948

Immediate cause of death Acute Cardiac Failure DURATION Sudden

Due to Chr. Arthritis of 4 mo.

Due to Lumbar Vertebra

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings: \_\_\_\_\_

Df operations \_\_\_\_\_

Df autopsy \_\_\_\_\_

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured et work? \_\_\_\_\_

23. SIGNATURE David R. Brewer M.D. M. D. or other \_\_\_\_\_

Address Clear Spring Md Date signed 2/23/48

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

FEB 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 13102 02035 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 Years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 2 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Rural Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hagerstown Route # 4  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

James H. Dodson

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Dodson  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) June 13, 1877  
 8. AGE: Years 70 Months 8 Days 8 If less than one day ..... hrs. .... min.

9. Birthplace Rappahannock County Virginia  
 (Town, county, and state)  
 10. Usual occupation Employee Supplie Jone Wills  
Milk Co. Retired  
 11. Industry or business  
 12. Name Patrick Dodson  
 13. Birthplace Virginia  
 14. Maiden name Mary Woodward  
 15. Birthplace Virginia

16. Informant Mrs. Mary Dodson  
 Address Hagerstown, Route # 4, Md.  
 17. Burial Burial Date thereof Feb. 24, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown, Maryland  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland  
 19. Feb. 24, 1948 Registrar Charles Powers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21-48 19..... at 6:11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1-48 19..... Feb 21-48 19.....  
 and that I last saw him alive on Feb 21-48 19.....

Immediate cause of death.....

Coroner - Raul L. Jones

DURATION

3 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed 2/24/48

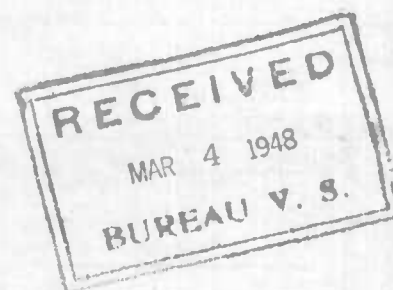


RECEIVED

FEB 26 1948

BUREAU V. S.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH

County **Washington**  
 City or town **Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **40 years**  
 Hospital, institution, or street address where death occurred:  
**38 Cramers Alley**  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Washington**  
 City or town **Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **W. Church St.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

**Emma J. Fincham**

## 3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**  
 6. (b) Name of husband or wife **Ellis Fincham**  
 6. (c) If alive, give age **66** years  
 7. Birth date of deceased (mo., day, yr.) **January 27, 1881**  
 8. AGE: Years **67** Months **0** Days **23** If less than one day  
 hrs. min.

9. Birthplace **Sperryville Rappahanna Va.**  
 (Town, county, and state)

10. Usual occupation **None**

11. Industry or business **None**  
 FATHER 12. Name **Charles Sisk**  
 13. Birthplace **Sperryville Va.**

MOTHER 14. Maiden name **Mae J. Leak**  
 15. Birthplace **Sperryville Va.**

16. Informant **Leonard Palmer Jr.**  
 Address **Hagerstown Md.**

17. Burial **Burial** Date thereof **Feb. 23-1948**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Smoketown Cemetery**  
**Near Martinsburg W. Va.**  
 Location **Scott F. Minnich & Son**  
**Hagerstown Md.**

18. Funeral director **Scott F. Minnich & Son**  
 Address **Hagerstown Md.**

19. **Feb. 23, 48** Registrar **Charles H. Bowers**  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH **February 20, 1948, 11:45a.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **February 17, 1948** to **Feb. 20, 1948**  
 and that I last saw him alive on **February 17, 1948**

Immediate cause of death **Chronic myocarditis**  
 DURATION **?**

Due to

Due to

Other conditions **None**

(Include pregnancy within 3 months of death)  
 Major findings of operations **No operation**  
 Date of op.  
 Autopsy results **No autopsy**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

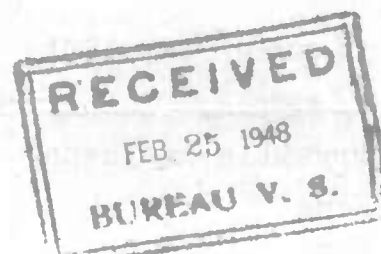
23. SIGNATURE **La. Buel**  
 Address **Hagerstown Md.** Date signed **2/21/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**RECEIVED**

FEB. 25 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

62

02038

1. PLACE OF DEATH: Washington  
County.....  
City or town..... Clear Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Cumberland Street  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland..... County..... Washington.....  
City or town..... Clear Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Cumberland Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Ruth Johnson Flory  
3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

8. (b) Name of husband or wife David H. Flory  
7. Birth date of deceased (mo., day, yr.) April 20, 1865 8. (c) If alive, give age years  
8. AGE: Years 82 Months 10 Days 3 If less than one day hrs. min.

9. Birthplace Washington County, Md.  
(Town, county, and state)  
Home Duties  
10. Usual occupation  
11. Industry or business

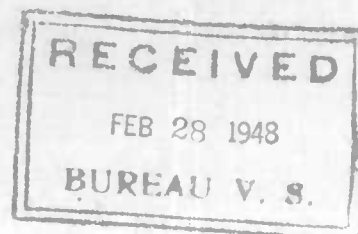
12. Name Robert Johnson  
13. Birthplace Washington County, Md.  
14. Maiden name Louisa Jacques  
15. Birthplace Washington County, Md.

16. Informant Mrs. Donald C. Haugh  
Address Clear Spring, Md.

17. Burial Date thereof Feb. 26-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Paul's Cemetery  
Location Near Clear Spring, Md. Route 40  
Snyder-Rowland Funeral Home  
18. Funeral director Snyder-Rowland Funeral Home  
Address Clear Spring, Md.

19. Feb 26 19 48 Joseph W. Murray Registrar  
(Date rec'd by registrar)

MEDICAL CERTIFICATION  
20. DATE OF DEATH Feb. 23, 1948 19 48 PM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 19 48 to Feb 23 19 48 and that I last saw him alive on Feb 22 19 48  
Immediate cause of death Chr. Myocardial Sclerosis DURATION 1 year  
Due to  
Due to  
Other conditions Carcinoma of Breast 6 mo.  
(Include pregnancy within 3 months of death)  
Major findings of operations Amputation of RT Breast Nov 1947  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE David R. Brewer M.D. M. D. or other  
Address Clear Spring Md. Date signed 2/25/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 1 hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Clear Spring, Md. R.D.# 1  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Linda Lee Fritz

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) February 28, 1946  
 6. (c) If alive, give age ..... years

8. AGE: Years 1 Months 11 Days 27 It less than one day  
 .... hrs. .... min.

9. Birthplace Washington Co. Md  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Haskin E. Fritz  
 13. Birthplace Cumberland, Maryland

MOTHER 14. Maiden name Martha C. Rubeck  
 15. Birthplace Franklin Co. Penna.

16. Informant Mr. Haskin Fritz  
 Address Clear Springs, Md. Route #1

17. Burial Burial Date thereof Feb. 27, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fairview Cemetery  
 Location Mercersburg, Penna.

18. Funeral director Snyder - Rowland  
 Address Clear Spring, Maryland

19. Feb. 26, 1948 Charles H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 19 48 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... 19....., to ..... 19.....  
 and that I last saw h..... alive on ..... 19.....

Immediate cause of death.....  
2nd & 3rd degree burns of  
 Due to face, upper extremities  
and body

## DURATION

1 1/2 hr

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results No  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Feb. 24, 1948  
 Accident, suicide, or homicide accident Date of .....  
 Where did injury occur? R.D.#1, Clear Springs, Md.  
 (City or town) (County) (State)

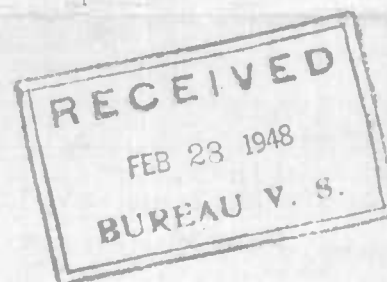
Injured at home, farm, industry, public place (where?) Home  
 Means of injury Clothes on fire Injured at work?

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAM.  
Hagerstown, Md. WASH. CO., MD.  
 Address..... Date signed Feb. 25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 1/2 months

Hospital, institution, or street address where death occurred:

Peterson Hospital  
How long in hospital or institution? 5 1/2 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland, County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3336 Catow Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie E. Geer

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

George

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 4, 1860 (?)

8. AGE:

Years

Months

Days

If less than one day

871124

hrs.

min.

9. Birthplace

Howard Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

David Tucker

13. Birthplace

Baltimore, Md.

14. Maiden name

Ann Elizabeth Tucker

15. Birthplace

Howard Co., Md.

16. Informant

Bruce W. Geer

Address

3336 Catow Ave. Balt., Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

March 1, 1948

Cemetery or crematorium

Rowdon Park

Location

Balt., Md.

18. Funeral director

Rev. C. and B. M. Walters

Address

Pratt, Tucker Sts

19. (Date recd by registrar)

3/119. 48A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 2819. 48 at 11:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1019. 47

to

Feb 2819. 48

and that I last saw him alive on

Feb 2719. 48

Immediate cause of death

Gangrene of right foot 2 mo.

DURATION

Due to

Arteriosclerosis?

Due to

and diabetes mellitus

Other conditions

Emphysema of abdominal aorta

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas M. Armstrong

M. D. or other

Address

Peterson Hospital

Date signed

Feb 28, 1948Cascade, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 Years  
 Hospital, institution, or street address where death occurred:  
941 Concord St.  
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 941 Concord St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

FRAY ALBERT GOETZ

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Annie E.  
 6. (c) If alive, give age 70 years  
 7. Birth date of deceased (mo., day, yr.) April 7 1875  
 8. AGE: Years 72 Months 10 Days 5 If less than one day  
hrs. min.

9. Birthplace Greencastle Franklin Co. Pa.  
 (Town, county, and state)  
 10. Usual occupation Tinner  
 11. Industry or business Own Business  
 12. Name Godfrey Goetz  
 13. Birthplace Germany  
 14. Maiden name Ellen Graham  
 15. Birthplace Upton Pa.

16. Informant Mrs. Annie E. Goetz  
 Address Hagerstown Md.  
 17. Burial Date thereof 12/14/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Feb. 14. 1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1948 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 10-48 to Feb 12-48  
 and that I last saw him alive on Feb 11-48  
 Immediate cause of death

Cerebral Hemorrhage  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE R. E. W. [Signature] M. D. or other  
 Address Hagerstown Md. Date signed 2/12/48

RECEIVED

FEB 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

02042

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hagerstown Police HeadquartersHow long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 29 No. Foundry St  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

CHALMERS SMITH GORDON

## 3. (b) Social Security Number

213-18-8846

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower6. (b) Name of husband or wife Edith7. Birth date of deceased (mo., day, yr.) June 14 18898. AGE: Years Months Days It less than one day  
58 8 9 hrs. min.9. Birthplace Greencastle Franklin Co. Pa.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business W.M.R.R.12. Name William B. Gordon13. Birthplace Shady Grove Pa.14. Maiden name Harriett Rummell15. Birthplace State Line Pa.16. Informant Paul W. GordonAddress Hagerstown Md.17. Burial Date thereof 2/26/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Feb. 26 19 48 Boast H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feby. 23 1948 19 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Acute alcoholic narcosis

Due to.....

Chronic alcoholism

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations None

..... Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

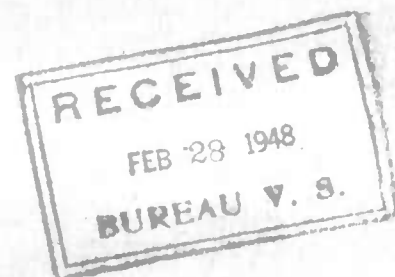
Accident, suicide, or homicide Yes Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.  
WASH. CO., MD.Address Hagerstown, Md. Date signed 2/25/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02043

302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 years  
 Hospital, institution, or street address where death occurred:  
901 Chestnut St.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 901 Chestnut St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lydia Grace Gossard

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife David Albert Gossard  
 6. (c) If alive, give age 70 years  
 7. Birth date of deceased (mo., day, yr.) Jan. 7, 1884  
 8. AGE: Years 64 Months 1 Days 12 If less than one day  
hrs. min.

9. Birthplace Near Williamsport, Wash., Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

At Home

FATHER

12. Name

Elmer Curfman

13. Birthplace

Near Wilson, Maryland.

MOTHER

14. Maiden name

Belle Ashe

15. Birthplace

Near Kemps Mill, Maryland.16. Informant Mr. David Albert Gossard  
Address 901 Chestnut St., Hagerstown, Md.17. Burial Date thereof Feb. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Maryland.18. Funeral director Mrs. Edith V. LeafAddress Williamsport, Maryland.19. Feb. 20, 1948 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948 at 5:25 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
Dec - 1947 to Feb 19 1948  
and that I last saw him alive on Feb 18 1948Immediate cause of death Diabetes  
Cardio Vascular - Renal  
Disease

DURATION

2 Year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md Date signed 2/20/48

RECEIVED

FEB 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Wilson, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Gateway Nursing Home  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Hotel Hamilton  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Lewis Scott Hamilton

## 3.(b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) May 5, 1880  
 8. AGE: Years 67 Months 8 Days 28 If less than one day  
 6.(c) If alive, give age... years  
 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Retired Salesman  
 11. Industry or business

12. Name William H. A. Hamilton  
 13. Birthplace Hagerstown, Maryland  
 14. Maiden name Alice Gray  
 15. Birthplace Hagerstown, Maryland

16. Informant Mrs. Edith Hunter  
 Address Washington, D. C.

17. Burial 2-5-48 Date thereof (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. 2-4-48 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 48 at 7 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct 9 19 43 to Feb 2 19 48  
 and that I last saw him alive on Feb 2 19 48

Immediate cause of death  
Myocardial dilatation  
Arteriosclerosis  
myocarditis chl

## DURATION

1/30/48

Due to Arteriosclerosis  
myocarditis chl  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

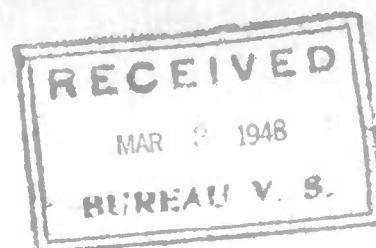
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE H. S. Porterfield M.D.  
 M. D. or other  
 Address 136 W. Washington Date signed 2/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

186a

02045

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural Sharpsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 Years  
 Hospital, institution, or street address where death occurred:  
Sharpsburg Route # 1  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Rural Sharpsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Sharpsburg Route # 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Maude Belle Harris3. (b) Social Security Number  
None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife		
6. (c) If alive, give age _____ years		
7. Birth date of deceased (mo., day, yr.) <u>September 12, 1870</u>		
8. AGE: Years <u>77</u>	Months <u>5</u>	Days <u>14</u>
If less than one day _____ hrs. _____ min.		

9. Birthplace... Charlottesville, Virginia.  
 (Town, county, and state)  
 10. Usual occupation... Home duties  
 11. Industry or business  
 FATHER  
 12. Name... George K. Harris  
 13. Birthplace... Virginia  
 MOTHER  
 14. Maiden name... Nancy  
 15. Birthplace... Virginia

18. Informant... Mrs. Roy Knode  
 Address... Sharpsburg Route # 1, Maryland  
 17. Burial... Burial Date thereof... Feb. 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Bakersville Cemetery  
 Location... Bakersville, Maryland  
 18. Funeral director... Fred W. Kraiss  
 Address... Hagerstown, Maryland  
 19. 2-28-48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb. 26, 1948 6:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death... Senility  
Fractured skull (fell down steps)  
 Due to... 1 hr.  
 Due to...  
 Other conditions

## DURATION

1 hr.

(Include pregnancy within 8 months of death)

Major findings of operations... None  
Date of op.Autopsy results... None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Accident Date of... 2/26/48  
 Where did injury occur? Sharpsburg Wash. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Home  
 Means of Injury Fell down steps Injured at work? No

23. SIGNATURE... D. Robert Wells DEPUTY MEDICAL EXAM.  
 Address... Hagerstown, Md. WASH. CO., MD.  
 M. D. 2/27/48  
 Date signed

RECEIVED

MAR 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
52 Harmons Alley  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 52 Harmons Alley  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Lester D. Hart

## 3.(b) Social Security Number

214-09-9354

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) Not Known  
 6.(c) If alive, give age..... years  
 8. AGE: Years 39 Months ..... Days ..... If less than one day ..... hrs. .... min.

9. Birthplace... Not Known  
 (Town, county, and state)  
 10. Usual occupation... Laborer  
 11. Industry or business.....  
 12. Name... Not Known  
 13. Birthplace... Not Known  
 14. Maiden name... Not Known  
 15. Birthplace... Not Known

16. Informant... Julia Anderson  
 Address... Downingtown, Pa.  
 17. Burial Date thereof... 3-3-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Rose Hill Cemetery  
 Location... Hagerstown, Maryland

18. Funeral director... William Downey  
 Address... Hagerstown, Maryland  
 19. Mar. 3, 48 Black/Bowen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1948 at 11: A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., 10....., 19.....  
 and that I last saw him..... alive on ..... 19.....

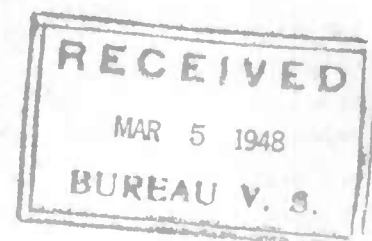
Immediate cause of death..... DURATION  
Vascular hypertension xx ?  
 Due to... arteriosclerotic kidney  
 Due to... disease  
chr. congestive myocardial  
 Other conditions... heart failure  
 (Include pregnancy within 3 months of death)

Major findings of operations... none Date of op. ....  
 Autopsy results... as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... No Date of .....  
 Where did injury occur? ..... (City or town) ..... (County) ..... (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....

23. SIGNATURE... A. Robert Wells DEPUTY MEDICAL EXAMINER  
 WASH. CO., MD.  
 Address... Hagerstown, Md. Date signed... 3/3/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 930

02047 303

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural Big Pool  
 (If outside city or town limits, write RURAL and give nearest town)  
Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

Big Pool

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Rural Big Pool  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William A. Hart

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Anna E. Hart

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 5, 1860

8. AGE: Years 87 Months 11 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington County, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business Retired Farmer12. Name Henry Hart13. Birthplace Washington County, Md.14. Maiden name Susan Miller15. Birthplace Washington County, Md.16. Informant Mrs. Katherine ReedAddress Big Pool, Md.17. Burial Date thereof Feb. 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Park Head Cemetery  
Near Clear Spring, Md. Route 40W

Location \_\_\_\_\_

18. Funeral director Snyder-Rowland Funeral HomeAddress Clear Spring, Md.19. Feb-11 48 Joseph W. Murray  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1948 196:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1946 to Feb. 8, 1948  
 and that I last saw him alive on Feb. 8, 1948

Immediate cause of death

Myocardial Sclerosis DURATION 3 yrs.

Due to Arterio Sclerosis 10 yrs.

Due to \_\_\_\_\_

Other conditions Ch. Bronchial Asthma 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

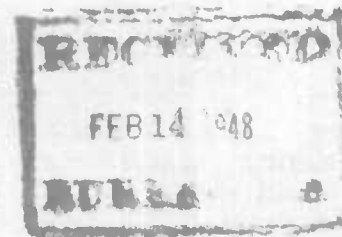
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE David P. Brewer M.D.

M. D. or other \_\_\_\_\_

Address Clear Spring Md. Date signed 2/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02048

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Washington  
 City or town Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Williamsport Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Agnes Mary Hamken  
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) May 6, 18718. AGE: Year 76 Months 8 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Williamsport Washington Md10. Usual occupation Clerk U.S. Gov. Office D.C.

11. Industry or business \_\_\_\_\_

12. Name James Hamken13. Birthplace Williamsport Md14. Maiden name Mary Sue Mendelsohn15. Birthplace Williamsport Md16. Informant Mrs. Albert HamkenAddress Williamsport Md17. Burial Date thereof 2, 15, 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory PrincetonLocation Williamsport Md18. Funeral director Edlich & SonsAddress Williamsport Md19. 2/15/48 19. Mrs. E. Lee McElroy

(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 19 48, at 12:34 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 19 48, to Feb. 12 19 48.and that I last saw him alive on Feb. 12 19 48.Immediate cause of death Large abdominal mass with markedclinical involvementDue to Trach. malignancy

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address Williamsport Md Date signed 2/13/48

RECEIVED

FEB 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02049

Reg. Dist. No. 306

## 1. PLACE OF DEATH:

County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town) 10 years  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Smithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

EARL L. HECK

## 3. (b) Social Security Number

207-01-4042

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Evelyn Huff Heck  
 6. (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 17, 1907

8. AGE: Years 40 Months 4 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cameron, Ohio County, W.Va.  
 (Town, county, and state)

10. Usual occupation Inspector at Fairchilds' Corp.

## 11. Industry or business

12. Name Clyde B. Hall  
 13. Birthplace Cameron, W.Va.

14. Maiden name Rose Courtwright  
 15. Birthplace Cameron, W.Va.

16. Informant Mrs. Earl L. Heck  
 Address Smithsburg, Md.

17. Burial 2/6/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Ringgold Union Cemetery  
 Location Ringgold, Md. Hagerstown # 5

18. Funeral director Walter J. Moore  
 Address 271 Church St. Tayneboro, Pa.

19. Feb 6 1948 Geo H Ferguson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1948, at 4:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4, 1948 to Feb 4, 1948 and that I last saw him alive on Feb 4, 1948

Immediate cause of death Pulmonary hemorrhage

Due to Far advanced bilateral pulmonary tuberculosis

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Walter J. Woffinger  
1225 Broad Street  
 Address Wayneboro, Penna Date signed 2-2-48





Evidence for change of  
street address shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02050

Form No. G 116 JUN 10 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington  
City or town..... Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 32 years  
Hospital, institution, or street address where death occurred:  
Washington County Home  
How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
City or town..... Hagerstown, 64 Wayside Ave.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Washington County Home  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles C. Hite

3. (b) Social Security Number  
NONE

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Lillian F. Hite  
6. (c) If alive, give age 74 years  
7. Birth date of deceased (mo., day, yr.) June 22, 1876  
8. AGE: Years 71 Months 8 Days 7 If less than one day ..... hrs. .... min.

9. Birthplace Bloomery, W. Va.  
(Town, county, and state)  
10. Usual occupation Watchmaker  
11. Industry or business Own Business  
12. Name Jacob Hite  
13. Birthplace Bloomery, W. Va.  
14. Maiden name Frances Pangle  
15. Birthplace Middletown, Va.

16. Informant Mrs. Earl Sites  
Address Baltimore, Maryland  
17. Burial Date thereof 3-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Mt. Hebron Cemetery  
Location Winchester, Va.

18. Funeral director C. M. Suter & Sons  
Address Hagerstown, Maryland

19. Date rec'd by registrar March 3, 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29<sup>th</sup> 1948 at 3<sup>30</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to Feb 29 1948  
and that I last saw him alive on Feb 28<sup>th</sup> 1948

Immediate cause of death  
Cerebral Hemorrhage 4 days  
Due to Hemiplegia rt. 4 days  
Due to Hypertensive Cardiovascular disease 5 yrs.  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

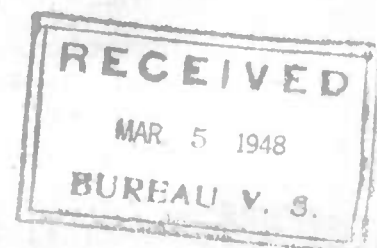
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Ernest F. P. M.D.  
M. D. or other  
Address Hagerstown Md Date signed 3/1/48

MARGIN RESERVED FOR BINDING

VS-415 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 5 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02051 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 years  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 205 S. Mont Valla Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

Helen Margaret Hite

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Leroy Sylvester Hite

7. Birth date of deceased (mo., day, yr.) July 19, 1901 5. (c) If alive, give age..... years

8. AGE: Years 46 Months 6 Days 16 If less than one day..... hrs. .... min.

9. Birthplace Lykens, Pa.  
(Town, county, and state)

10. Usual occupation Home Duties

### 11. Industry or business

12. Name William H. Shoop

13. Birthplace Penn.

14. Maiden name Rebecca H. Reidinger

15. Birthplace Penn.

16. Informant Leroy S. Hite

Address 205 S. Mont Valla-Ave. Hagerstown, Md.

17. Burial Date thereof Feb. 7-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Perry Heights Cemetery

Location Marysville, Pa.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Feb. 5, 48 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948 at 12:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2, 1948 to Feb. 4, 1948 and that I last saw him alive on February 4, 1948

Immediate cause of death Myocardial thrombosis DURATION 2 days

Due to.....

Due to.....

Other conditions Diabetes mellitus About 11 years  
(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results Autopsy refused  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Ra Bell M. D. or other  
Address Hagerstown, Md. Date signed 2/4/48

MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 7 1948  
BUREAU V C

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02052

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County... Washington  
City or town... Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?... 45 years  
Hospital, institution, or street address where death occurred:  
442 North Potomac Street  
How long in hospital or institution?...

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 442 North Potomac Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war... World War 1

### 3. (a) FULL NAME

Dr. Frank Newcomer Hoffmeier

### 3. (b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Nellie Mc. Hoffmeier  
6.(c) If alive, give age 70 years  
7. Birth date of deceased (mo., day, yr.) September 15, 1876  
8. AGE: Years 71 Months 5 Days 4 If less than one day hrs. min.

9. Birthplace Middletown, Fred. Co. Md.  
(Town, county, and state)  
10. Usual occupation Retired Roentgenologist  
11. Industry or business

FATHER 12. Name Rev. Thomas F. Hoffmeier  
13. Birthplace Lancaster, Pa.  
MOTHER 14. Maiden name Sallie M. Ankeney  
15. Birthplace Hagerstown, Maryland

16. Informant Mrs. Frank Hoffmeier  
Address Hagerstown, Maryland  
17. Burial Date thereof 2-23-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Zion Reformed Cemetery  
Hagerstown, Maryland  
Location C. M. Suter & Sons  
18. Funeral director Hagerstown, Maryland  
Address

19. Feb. 21, 1948 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/48 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940 to 2-19-48  
and that I last saw him alive on 2/18/48  
Immediate cause of death Probable acute coronary occlusion  
DURATION Did in few minutes  
Due to  
Due to  
Other conditions  
(Include pregnancy within 8 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE John H. Horn M. D. or other  
154 W. Washington St.  
Address Hagerstown, Md. Date signed 2/20/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02053

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Washington  
 City or town Williamsport, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
Springfield Farm near Williamsport  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Near Williamsport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles W. Humrichouse

## 3. (b) Social Security Number

058-03-3385

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) October 28, 1876  
 8. AGE: Years 71 Months 3 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Retired Broker

11. Industry or business \_\_\_\_\_

12. Name William H. Humrichouse

13. Birthplace Baltimore, Maryland

14. Maiden name Annette Hart

15. Birthplace Annapolis, Maryland

16. Informant Minford Humrichouse

Address Philadelphia, Pa.

17. Burial 2-13-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. 2/12/48 19 Mrs. E. Lee M. Elvey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 19 48 10<sup>10</sup> P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26 19 48 to Feb. 10 19 48  
 and that I last saw him alive on Feb. 10 19 48

Immediate cause of death Melanoides of heart  
(Atherosclerosis)

Due to \_\_\_\_\_

Due to Arteriosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE E. Lee M. Elvey M. D. or other \_\_\_\_\_

Address Williamsport Md. Date signed 2/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
FEB 14 1948  
BUREAU OF A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

### 1. PLACE OF DEATH:

County Washington  
City or town Boonsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 years  
Hospital, institution, or street address where death occurred: Boonsboro R. 2  
How long in hospital or institution? at home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Boonsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boonsboro R. 2  
(If rural, give LOCATION)  
2(a) If veteran, name war no

### 3. (a) FULL NAME

Clara Sophia Hutzell

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Russell E. Hutzell  
7. Birth date of deceased (mo., day, yr.) March 31, 1886  
6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 61 Months 8 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Belleville Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name John Smith

13. Birthplace Belleville Wash. Co. Md.

14. Maiden name Susan Poffenbarger

15. Birthplace Belleville Wash. Co. Md.

16. Informant Russell E. Hutzell

Address Boonsboro Md. R. 2

17. Burial Date thereof February 18, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Chas. J. Bait 9300

Address Boonsboro Md.

February 18, 1948 John H. Best  
Date rec'd by registrar Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to Feb. 16, 1948

and that I last saw him alive on Feb. 15, 1948

Immediate cause of death Acute Myocardial Infarction

Due to Arterial Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John H. Best - M.D. M. D. or other

Address Boonsboro Md. Date signed 2/17/48

MARGIN RESERVED FOR BINDING

I

VS A15

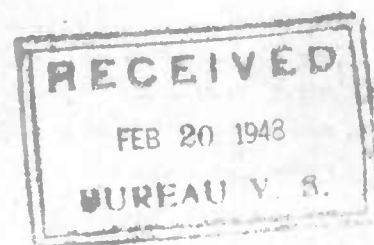
9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade

830

02054



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line corrected age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02055

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 45 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 56 West North Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Lemuel F. Johns

## 3. (b) Social Security Number

217-09-9816

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Elsie Johns  
 6. (c) If alive, give age 48 years  
 7. Birth date of deceased (mo., day, yr.) May 10, 1891  
 8. AGE: Years 56 Months 9 Days 4 If less than one day  
 .... hrs. .... min.

9. Birthplace McKeesport, Pa.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business  
 12. Name Charles Johns  
 13. Birthplace Not Known  
 14. Maiden name Annie Hardy  
 15. Birthplace Not Known

16. Informant Mrs. Elsie Johns  
 Address Hagerstown, Maryland  
 17. Burial Date thereof 2-17-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland  
 18. Funeral director William H. Downey  
 Address Hagerstown, Maryland

19. Feb. 17, 1948 Charles H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1948 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Feb 10, 1948 to Feb 14, 1948  
 and that I last saw him alive on Feb 13, 1948

## Immediate cause of death

Hypertensive cardio-vascular disease

## DURATION

years

## Due to

## Due to

## Other conditions

hepato-sclerosisyears

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

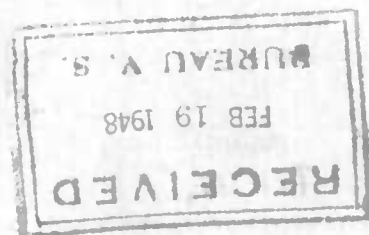
Means of injury Injured at work?

## 23. SIGNATURE

R. S. Stauffer, M.D.

M. D. or other

Address Hagerstown, Md Date signed Feb 16, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2000 02056 20

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 10 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Rural Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Chewsville Pike- R D 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War 11 (Navy)

## 3.(a) FULL NAME

Clarence E. Jones

## 3.(b) Social Security Number

256-24-4251

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Alice J. Jones  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 19, 1924  
 8. AGE: Years 23 Months 9 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Macon, Georgia  
 (Town, county, and state)  
 10. Usual occupation Truck Farmer  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name Benjamin Jones  
 13. Birthplace Jeffersonville, Georgia  
 MOTHER 14. Maiden name Eunice J. Harrell  
 15. Birthplace Jeffersonville, Georgia  
 16. Informant Mrs. Alice J. Jones  
 Address Hagerstown, Md. R D 1

17. Burial Rest Haven Cemetery Date thereof Feb. 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hagerstown, Md.  
 Location Fred W. Kraiss  
 18. Funeral director Hagerstown, Md.  
 Address

19. Feb. 16, 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948 at 9:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13, 1948 to February 13, 1948  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Fetus of undetermined origin  
 Due to Suppuration in a possible cause of death.  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results No definite cause of death ascertained.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. Fayman, M.D. M. D. or other \_\_\_\_\_  
 Address Hagerstown, Md. Date signed 14 Feb 1948

RECEIVED

FEB 18 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town R.F.D. # 5 Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHN HARVEY KING

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Barbara C. King6. (c) If alive, give age 77 years

## 7. Birth date of

deceased (mo., day, yr.)

August 10 1869

## 8. AGE:

Years

78

Months

6

Days

1

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Leitersburg, Maryland

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## FATHER

## 12. Name

Josiah L. King

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Barbara A. Wetzel

## 15. Birthplace

Unknown

## 16. Informant

Harry W. King

## Address

144 S. Church St., Waynesboro, Pa

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

REMOVAL FEB 11 1948  
(month) (day) (year)

## Cemetery or crematory

GREEN HILL CEMETERY

## Location

WAYNESBORO, PENNA.

## 18. Funeral director

J. Spaulding Poe

## Address

WAYNESBORO, PENNA.

## 19.

(Date rec'd by registrar)

19

Feb. 11, 48

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Feb 11 1948 at 2:10 A. M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 9 1948 to Feb 11 1948and that I last saw him alive on Feb 10 1948

## Immediate cause of death

Uremia

## DURATION

1 week plus

## Due to

Benign prostatic hypertrophy 2 yrs.

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

## 23. SIGNATURE

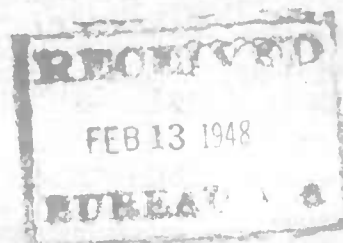
J. L. Houghton, M.D.

M. D. or other

## Address

Hagerstown, MdDate signed Feb 11, 1948

CERTIFICATE OF DEATH



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02058

Reg. Diat. No. 306

## 1. PLACE OF DEATH

County Washington  
 City or town near Smithsburg Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Smithsburg Md. R. 2.  
 How long in hospital or institution at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town near Smithsburg Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Smithsburg Rd. R. 2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No.

## 3. (a) FULL NAME

John Thomas Kinsey

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Milva Kinsey  
 7. Birth date of deceased (mo., day, yr.) September 30, 1892 6. (c) If alive, give age 55 years  
 8. AGE: Years 75 Months 4 Days 20 If less than one day hrs. min.

9. Birthplace Mt. Lema Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business

MOTHER FATHER  
 12. Name John T. Kinsey  
 13. Birthplace Mt. Lema Wash. Co. Md.  
 14. Maiden name Sophia Ambrose  
 15. Birthplace Wash. Co. Md.

16. Informant Mrs. Milva Kinsey  
 Address Smithsburg Md. R. 2.  
 17. Burial Date thereof March 2, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bonsheo Cemetery  
 Location Bonsheo Md.  
 18. Funeral director Wm. J. Bart & Son  
 Address Bonsheo Md.

19. Mar 1st 1948 Geo. W. Ferguson  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1948 at 10 A  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 1948 to Feb 28 1948  
 and that I last saw h. alive on Feb 28 1948

Immediate cause of death Operative of Hemorrhage 28 hrs  
 Due to Arterio - 5 clots of 15 yrs

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. G. H. O'Brien M. D. or other \_\_\_\_\_  
 Address Smithsburg Date signed 3/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**  
 County.....  
 City or town.....**Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....**63 years**  
 Hospital, institution, or street address where death occurred:  
**117 N. Cannon Ave.**  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....**Maryland**.....County.....**Washington**  
 City or town.....**Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
**117 N. Cannon Ave.**  
 Street No.....  
 (If rural, give LOCATION)  
 -----  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Staida M. Kinsey**

## 3. (b) Social Security Number

-----

4. Sex.....**Female**  
 5. Color or race.....**White**  
 6. (a) Single, married, widowed, or divorced.....**Widowed**  
 6. (b) Name of husband or wife.....**George G. Kinsey**  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....**May 13, 1884**  
 8. AGE: Years.....**63** Months.....**9** Days.....**3**  
 If less than one day.....hrs. ....min.

9. Birthplace.....**Hagerstown Wash. Md.**  
 (Town, county, and state)  
 10. Usual occupation.....**None**  
 11. Industry or business.....**None**  
 12. Name.....**Joseph A. Baker**  
 13. Birthplace.....**Hagerstown Md.**  
 14. Maiden name.....**Anna K. Jones**  
 15. Birthplace.....**Cavetown Md.**

16. Informant.....**Earl Kinsey**  
 Address.....**Hagerstown Md.**  
 17. Burial.....**Burial**.....Date thereof.....**Feb. 18, 1948**  
 (Burial, cremation, or removal, Which?).....(month) (day) (year)  
 Cemetery or crematory.....**Rose Hill Cemetery**  
**Hagerstown Md.**  
 Location.....**Scott F. Minnich & Son**  
 18. Funeral director.....**Hagerstown Md.**  
 Address.....

19. **Feb. 18, 1948**.....**Chas. H. Bowles**  
 (Date rec'd by registrar).....Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....**February 16, 1948** at **6 a.** M.

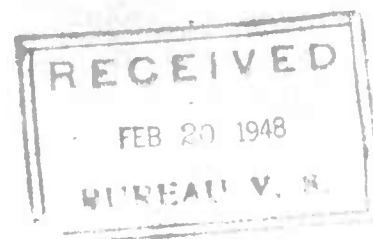
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**Feb. 15, 1948** to **Feb. 16, 1948**  
 and that I last saw her alive on **Feb. 15, 1948**

Immediate cause of death.....**Cerebral thrombosis**  
 DURATION.....  
 Due to.....**Mural thrombus**.....?  
 Due to.....**Arterio-sclerosis**.....**6 mos.**  
 Other conditions.....**General Arteriosclerosis**  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide.....Date of.....  
 Where did injury occur?.....(City or town).....(County).....(State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury.....Injured at work?

23. SIGNATURE.....**Robert V. Campbell M.D.**  
 M. D. or other.....  
 Address.....**Hagerstown**.....Date signed.....**2/16/48**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02060

Reg. Dist. No. 302

1. PLACE OF DEATH:  
 County... Washington  
 City or town... Halfway  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 years  
 Hospital, institution, or street address where death occurred:  
1921 Virginia Ave.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Halfway  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1921 Virginia Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME  
Laura May Lindsey

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Samuel E. Lindsey  
Deceased 6. (c) If alive, give age years  
 7. Birth date of April 21, 1867  
 deceased (mo., day, yr.)

8. AGE: Years 80 Months 9 Days 23 It less than one day  
 hrs. min.

9. Birthplace Near Clearspring, Wash. Maryland  
 (Town, county, and state)

10. Usual occupation Housewife  
At Home

11. Industry or business

12. Name Samuel Davis  
 13. Birthplace Near Clearspring, Maryland.

14. Maiden name Matilda Dellinger  
 15. Birthplace Near Clearspring, Maryland.

16. Informant Mrs. Howell Vickers  
 Address 1921 Virginia Ave.; Halfway, Md.

17. Burial Date thereof Feb. 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. View Cemetery  
 Location Sharpsburg, Maryland.

18. Funeral director Edith Leaf  
 Address Williamsport, Maryland.

19. Feb. 16, 1948  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

Feb/13/48 11P

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 28 1936 to Feb. 13, 1948  
 and that I last saw her alive on Feb. 13, 1948

Immediate cause of death.....  
Senility

Due to Umbilical hernia 20yrs

Due to intestinal obstruction 3 d

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results... No  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... No Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells, M.D.  
Nagawatsun, Md. M. D. 2/16/48  
 Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

FEB 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**  
**Hagerstown**  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **10 months**  
 Hospital, institution, or street address where death occurred:  
**527 Reynolds Ave.**  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
**Maryland** State **Washington** County  
**Hagerstown**  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
**527 Reynolds Ave.**  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**John C. Linger**

## 3. (b) Social Security Number

-----

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Widowed**  
 6.(b) Name of husband or wife **Mary E. Linger**  
 7. Birth date of deceased (mo., day, yr.) **May 8, 1876**  
 6.(c) If alive, give age..... years  
 8. AGE: Years **71** Months **9** Days **19** If less than one day  
 hrs. min.

9. Birthplace **Horner Rt. 1 Lewis Co. W.Va.**  
 (Town, county, and state)  
 10. Usual occupation **Teacher**  
 11. Industry or business **Public School**  
 12. Name **Perry H. Linger**  
 13. Birthplace **Lewis Co. W.Va.**  
 14. Maiden name **Martha J. Simons**  
 15. Birthplace **Lewis Co. W. Va.**

16. Informant **Roderick Linger**  
 Address **Martinsburg W.Va.**  
 17. **Removal** Date thereof **Feb. 27, 1948**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory **Reger Chapel Cemetery**  
**Buckhannon W.Va.**  
 Location  
 18. Funeral director **Scott F. Minnich & Son**  
 Address **Hagerstown Md.**

19. **Feb 27** 19 **48** **Chas. H. Bowser**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **February 26** 19 **48** at **4:45p** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**5 July** 19 **48** to **26 Feb** 19 **48**  
 and that I last saw him alive on **26 Feb** 19 **48**

Immediate cause of death **Cerebral**  
**Accident**  
 DURATION  
**3 days**

Due to **Hypertensive cardio-**  
**vascular disease**  
 Due to.....

Other conditions **Cerebral Embolus**  
**May '47**  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE **John C. Linger MD**  
 M. D. or other  
 Address **Hagerstown Md** Date signed **2/27/48**

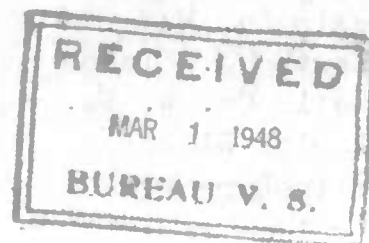
MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Houghton

02062

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 3 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 829 Spruce St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

LEVI NEWMAN MARLOWE

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife Sarah  
 6.(c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) May 21 1867  
 8. AGE: Years 80 Months 8 Days 18 If less than one day  
 hrs. min.

9. Birthplace Front Royal Warren Co. Va.  
 (Town, county, and state)  
 10. Usual occupation Wood Worker  
 11. Industry or business Retired  
 12. Name John Marlowe  
 13. Birthplace Front Royal Va.  
 14. Maiden name Amanda Berry  
 15. Birthplace Front Royal Va.  
 16. Informant Lathen Marlowe  
 Address Hagerstown Md.

17. Burial Date thereof 2/13/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Feb 11. 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 at 1 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Aug 16 1943 to Feb 9 1948  
 and that I last saw him alive on Feb 9 1948

Immediate cause of death chronic myocarditis DURATION 1 yr

Due to  
 Due to

Other conditions Carcinoma prostate 4 yrs +  
& metastases ?  
 (Include pregnancy within 3 months of death)

Major findings of operations Carcinoma prostate  
sections in 1943 Date of op. Aug 1943

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J R Houghton M.D. M. D. or other  
 Address Hagerstown Md Date signed Feb 9, 48



Evidence for change  
of age is shown on

FILM No. G 114 MAR 3 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

02063

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

54 North Jonathan St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hagerstown R#1 Beaver Creek  
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

DAVID JESSE MARTIN

3. (b) Social Security Number

215-26-2165

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Mary Martin

6.(c) If alive, give age 51 years

7. Birth date of

deceased (mo., day, yr.)

November 17, 1889

8. AGE:

Years

Months

Days

If less than one day

58

5

2

28

hrs.

min.

9. Birthplace Moorsville, Washington Co. Md.  
(Town, county, and state)

10. Usual occupation Fireman

11. Industry or business Soya Corp.

12. Name Jefferson Martin

13. Birthplace Mooreville Md.

14. Maiden name Eva Cline

15. Birthplace Mooreville Md

16. Informant Mrs Mary Martin

Address Hagerstown Md. R#1

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/15/48  
(month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Near Clearspring Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 17. 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

Feb/15/48

9 P

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

coronary occlusion

3d

Due to.....

acute ventricular fibrillation

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. or other

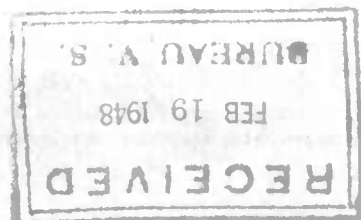
Address Hagerstown, Md. Date signed 2/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three years

Hospital, institution, or street address where death occurred:

61 Westside Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 61 Westside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Markus Clinton Mauck

## 3. (b) Social Security Number

219-05-2949

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Betty Irene Mauck6.(c) If alive, give age 81 years7. Birth date of deceased (mo., day, yr.) August 12, 1865

8. AGE: Years 82 Months 5 Days 24 If less than one day  
 ....hrs. ....min.

9. Birthplace Milldale, Warren, Virginia  
 (Town, county, and state)10. Usual occupation Laborer in Leather Tannery11. Industry or business Leather Tannery12. Name Robert Mauck13. Birthplace Milldale, Virginia14. Maiden name Rebecca Watkins15. Birthplace Milldale, Virginia16. Informant Russel B. MauckAddress RFD#1 Williamsport, Maryland17. Burial Date thereof Feb. 8, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Williamsport, Maryland.18. Funeral director Edith V. LeafAddress Williamsport, Maryland.19. Feb. 7, 48 Robert H. Brown  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1948 at 10:45 am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1948 to 2/6 1948and that I last saw him alive on Oct 31, 1948Immediate cause of death chronic Endo Carditis - ? -  
arterio-sclerosis - ? -

DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations 0Date of op. -

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of .....Where did injury occur? 0 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) 0Means of injury 0 Injured at work?23. SIGNATURE V. H. Miller M. D. or otherAddress Hagerstown Md Date signed 2/7 1948





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02065 302

## 1. PLACE OF DEATH:

County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

220 W. First Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 W. First Street

(If rural, give LOCATION)

2. (a) If veteran, name war...

## 3. (a) FULL NAME

ALCIE TRESA McELROY

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Joseph T. McElroy

8. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

October 20, 1896

8. AGE:

Years 51

Months 3

Days 13

If less than one day

hrs. min.

9. Birthplace...

Virginia

(Town, county, and state)

10. Usual occupation...

Home Duties

11. Industry or business

FATHER

12. Name... John A. Mays

13. Birthplace

Virginia

MOTHER

14. Maiden name... Mary Lynn

15. Birthplace

Virginia

16. Informant

Joseph T. McElroy

Address 220 W. First St.- Hagerstown, Md

17.

Burial

Date thereof Feb. 6-48  
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19.

Feb. 6, 1948  
(Date rec'd by registrar)

19.

B. H. Bowers  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1948 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1936 to Feb. 2, 1948  
and that I last saw her alive on Feb. 2, 1948

Immediate cause of death

Multiple Myeloma

Due to

chr. myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Multiple myeloma

Date of op. 10/2/47

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Robert Wells M.D.

M. D. on file

Address Hagerstown, Md. Date signed Feb. 4/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Victor Miller

02066

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Years  
 Hospital, institution, or street address where death occurred:  
510 Summit Ave.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 510 Summit Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

MRS LILLIAN ALLISON MILLESON

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Robert L. Milleson  
 6.(c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) March 12, 1892  
 8. AGE: Years 55 Months 11 Days 14 It less than one day hrs. min.

9. Birthplace Berryville, Clarke Co. Virginia  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home

FATHER 12. Name Christian W. Singhass  
 13. Birthplace Winchester Va.

MOTHER 14. Maiden name Virginia Allison  
 15. Birthplace Winchester Va.

16. Informant Robert L. Allison  
 Address Hagerstown Md.

17. Burial Date thereof 2/29/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Hebron Cemetery

Location Winchester, Fredrick Co. Va18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Feb. 27, 1948 Blaschke-Bowen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1948 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Jan 1, 1948 to 2/25, 1948  
 and that I last saw her alive on 2/25, 1948

Immediate cause of death

Carcinoma of Bladder  
" " " " " "  
Bladder cancer

DURATION

3-4  
years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

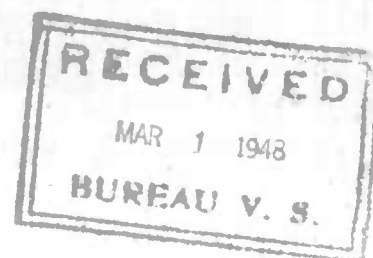
Means of injury Injured at work?

23. SIGNATURE

V. Miller  
Victor Miller

M. D. or other

Address Date signed 2/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington  
 City or town Clear Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Clear Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Odessa Lorraine Mills

## 3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 20, 1935 8.(c) If alive, give age 12 years

8. AGE: Years 12 Months 3 Days 13 If less than one day  
 ....hrs. ....min.

9. Birthplace Clear Spring, Md.  
 (Town, county, and state)

10. Usual occupation School Student

11. Industry or business

12. Name Harry C. Mills13. Birthplace Washington County, Md.14. Maiden name Susan Bridendolph15. Birthplace Washington County, Md.16. Informant Harry C. MillsAddress Clear Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Feb. 5-48  
 (month) (day) (year)

Cemetery or crematory St. Paul's CemeteryLocation Near Clear Spring, Md. Route 4018. Funeral director Snyder-Rowland Funeral HomeAddress Clear Spring, Md.

19. Feb 5 1948 Joseph W. Murray Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1948 11:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Feb 2 1948  
 and that I last saw him alive on Feb 1 1948

Immediate cause of death Sarcoma of right femur DURATION 4 mo  
metastases to  
skull and brain 3 mo

Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE David P. Brewer M.D. M. D. or other  
Clear Spring Md. Address Date signed 2/4/48

RECEIVED  
FEB 7 1948  
BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 54 years  
 Hospital, institution, or street address where death occurred:  
128 Wayside Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 128 Wayside Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Jennie Martha Minnich

## 3. (b) Social Security Number

--

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Harry Minnich  
 7. Birth date of deceased (mo., day, yr.) July 6, 1857 6. (c) If alive, give age years  
 8. AGE: Years 90 Months 7 Days 23 If less than one day hrs. min.

9. Birthplace Franklin Co., Penna.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Michael Diehl13. Birthplace Franklin Co., Penna.14. Maiden name Anna Shutter15. Birthplace Franklin Co., Penna.16. Informant Mrs. Mary RifeAddress Hagerstown, Md.17. burial Date thereof 3-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Scott F. Minnich & SonAddress Hagerstown, Md.19. Mar 2 48 Registrar Sherry Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 - 1948 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 - 1948 to Feb 29 1948  
 and that I last saw her alive on Feb 15 1948

Immediate cause of death arterio-sclerosis - chronic  
chronic  
Heart Disease  
Stability  
 DURATION 2

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

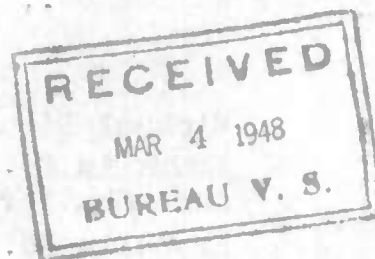
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Kirby S. Miller M. D.Address Hagerstown, Md. Date signed 2/29/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02069

93d

302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution?

6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No. E. Main Street  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

William Van Meter Moon

## 3. (b) Social Security Number

219-07-2531

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Sarah WexdebaughMoon6.(c) If alive, give age 59 years

7. Birth date of

deceased (mo., day, yr.)

Sept. 6, 1888

8. AGE:

Years

Months

Days

If less than one day

59512— hrs. — min.9. Birthplace Mt. Lake Park, Garrett Co., Md.

(Town, county, and state)

10. Usual occupation Mechanic11. Industry or business —12. Name Jonathan Whitfield Moon13. Birthplace Garrett Co., Md.14. Maiden name Millie Elizabeth Jenkins15. Birthplace Unknown16. Informant Sgt. Truman W. MoonAddress Frederick, Md.17. Burial Date thereof Feb. 22, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery Damascus Christian ChurchLocation Fulton Co. Penna. - near Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. Feb. 20, 1948 Registrar Charles Bowers  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1948, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 12, 1948 to Feb. 18, 1948and that I last saw him alive on Feb. 18, 1948

Immediate cause of death

Pneumonia, interstitial, chronic;  
pulmonary fibrosis  
Due to Silicosis ?

DURATION

Years

Due to

Other conditions Arterio-sclerotic heart  
disease  
(Include pregnancy within 8 months of death)Years

Major findings of operations

Date of op.

Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. S. Stauffer, M.D.

M. D. or other

Address Hagerstown, Md.Date signed Feb. 18, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

FEB 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington  
 City or town Breathedsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 months  
 Hospital, institution, or street address where death occurred:  
Maryland State Reformatory for Males  
 How long in hospital or institution? 11 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Brent Morris

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) December 25, 1925

8. AGE: Years 22 Months 1 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Charles County, Maryland  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Cleveland Morris13. Birthplace Maryland14. Maiden name No record

15. Birthplace \_\_\_\_\_

16. Informant Files Id. State Reform. MalesAddress Roxbury Md.

17. Removal Date thereof 2/17/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waldorf CemeteryLocation Waldorf Maryland18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Feb. 17, 1948 John H. Back  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 19 48 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that deceased died from  
Sept 15 19 47 to Feb 17 19 48  
 and that I last saw him alive on Feb 16 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION 1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

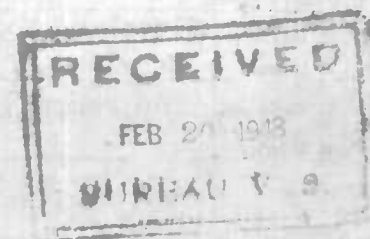
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other

Hagerstown, Md. Date signed 2-18-48  
 Address \_\_\_\_\_



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

02071

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Years  
 Hospital, institution, or street address where death occurred:  
611 George St.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 611 George St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

ALICE VIRGINIA HICKS MYERS

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife John Myers 6.(c) If alive, give age -- years  
 7. Birth date of deceased (mo., day, yr.) October 4, 1869  
 8. AGE: Years 78 Months 4 Days 14 If less than one day  
 hrs. min.

9. Birthplace... Martinsburg, Berkley Co., W. Va.  
(Town, county, and state)10. Usual occupation... House Wife11. Industry or business... Own Home

12. Name Jasper Hicks  
 13. Birthplace Greencastle Pa.  
 14. Maiden name Elizabeth Eversole  
 15. Birthplace Charlestown W. Va.

16. Informant Mrs. W. R. Sinns  
 Address Hagerstown, Md.

17. Burial 2/21/48 Date thereof (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Feb. 21, 48 (Date rec'd by registrar)  
Chas. H. Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... February 18, 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 1 1947 to Feb 18 1948  
 and that I last saw him alive on Feb 18 1948

Immediate cause of death  
Ch. Myocarditis  
Ch. Interstitial Nephritis  
 DURATION  
6 yrs  
6 yrs.

Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ....

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad MD  
Hagerstown, Md M. D. or other  
 Address... Date signed 2-20-48

RECEIVED

FEB 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural - Clearspring  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 2 yrs.

Hospital, institution, or street address where death occurred:

Gateway Nursing HomeHow long in hospital or institution? about 2 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Pectonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #1 Big Pool  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Harriet Weller Myers

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Samuel Myers7. Birth date of deceased (mo., day, yr.) May 20, 18608. AGE: Years 87 Months 9 Days 4 If less than one day \_\_\_\_\_9. Birthplace Washington Co., Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Samuel Weller13. Birthplace Maryland14. Maiden name Barbara Myers15. Birthplace Maryland16. Informant Mrs. Genevieve BeardAddress Route #1, Big Pool, Md.17. Burial Burial Date thereof Feb. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Stone Bridge Church of BrethrenLocation Fulton Co., Penna. - near Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 2-26 1948 Clear Spring Ford  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1948 at 8:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 25 1947 to Feb. 24 1948and that I last saw him alive on February 22 1948Immediate cause of death Arteriosclerotic heart diseaseDue to Arteriosclerotic gangrene

foot. Right

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations noneAntemortem none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Pauli Robert ColeAddress Clear Spring FordDate signed 2-26-48



RECEIVED

MAR 3 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

Reg. Dist. No. 02073

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 48 Years  
Hospital, institution, or street address where death occurred:  
Hagerstown R #4 Broadfording Road  
How long in hospital or institution? --

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Rural - Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 4 Broadfording Road  
(If rural, give LOCATION)  
2(a) If veteran, name war None

### 3. (a) FULL NAME

MRS BESSIE VIRGINIA NEIBERT

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Christian Neibert

6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 15, 1879

8. AGE: Years 68 Months 11 Days 16 If less than one day  
hrs. min.

9. Birthplace Clearspring, Washington Co. Md.  
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own Home

12. Name Jacob Kershner

13. Birthplace Falling Waters West Virginia

14. Maiden name Susan Christian

15. Birthplace Clearspring Md.

16. Informant Christian C. Neibert

Address Hagerstown R #4

17. Burial Date thereof 2/3/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery

Location Broadfording Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb 2, 48 Charles H. Howard  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 19 48 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 - 48 to Feb 1 - 48 and that I last saw alive on Feb 1 - 48

Immediate cause of death

Due to Sudden Cor

Due to Sudden Myocard

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. 7/2/48

Address Hagerstown Md. Date signed 7/2/48

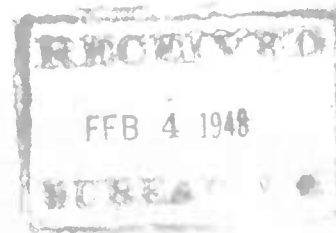
MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 02074 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
2026 Virginia Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
Maryland Washington  
 State... County...  
 City or town... Hagerstown, R.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 2026 Virginia Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

James B. Peterman

## 3. (b) Social Security Number

No

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife... Mary Magdeline Miller  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) November 3, 1856  
 8. AGE: Years 91 Months 5 Days 3 If less than one day... hrs. ... min.  
 9. Birthplace... Sharpsburg, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation... Retired Farmer  
 11. Industry or business

MOTHER 12. Name... George Peterman  
 13. Birthplace... Martinsburg, W. Va.  
 14. Maiden name... Mary Ann Mc Grow  
 15. Birthplace... Fredrick, Maryland

16. Informant... Mrs. Mary M. Peterman  
 Address... 2026 Virginia Ave. Hagerstown, Md.

17. Burial Date thereof Feb. 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mountain View Cemetery  
 Location... Sharpsburg, Maryland

18. Funeral director... Fred. W. Kraiss  
 Address... Hagerstown, Maryland

19. Feb. 12, 1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1948 10:10 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 18:48 to Feb. 8 19:48  
 and that I last saw him alive on Feb. 8 19:48

## Immediate cause of death

Arterio sclerotic  
Heart disease

## Due to

Coronary Occlusion

## Due to

Pulmonary Edema

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest J. Goldsmith M. D. or otherAddress Hagerstown Md Date signed 2/11/48

1947  
63  
1284

RECEIVED  
FEB 14 1948  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

410 Mitchell Avenue

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Mitchell Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Rachael Purdham

### 3. (b) Social Security Number

NONE

#### 4. Sex

Female

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Widow

#### 6. (b) Name of husband or wife

Charles W. Purdham

#### 6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) October 19, 1861

#### 8. AGE:

Years

86

Months

3

Days

25

If less than one day

hrs.

min.

9. Birthplace Stanley, Virginia  
(Town, county, and state)

10. Usual occupation Housework

#### 11. Industry or business

12. Name Elipah Pettit

13. Birthplace Virginia

14. Maiden name Mary Cave

15. Birthplace Virginia

16. Informant Mrs. J. C. Bowen

Address Hagerstown, Maryland

17. Burial Date thereof 2/13/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery  
Hagerstown, Maryland

Location

18. Funeral director C. M. Suter & Sons  
Address Hagerstown, Maryland

19. Feb. 14, 1948 Chas. H. Bowers  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/48 at 4:48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-1-40 1940 to 2-12-48  
and that I last saw her alive on 12-1-47 1947

Immediate cause of death

Senility

Due to

Due to Cerebral Vascular Lesion 13 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. S. S. M. D. or other

Address Hagerstown Date signed 2/24/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

FEB 17 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02076

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 DAYS  
 Hospital, institution, or street address where death occurred:  
1074 MARSHALL ST.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County WASHINGTON  
 City or town WILLIAMSPORT  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 122 N. ARTIZAN ST.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war NON-VET

## 3. (a) FULL NAME

RHODA BARBARA

## 3. (b) Social Security Number

RAMSEY

## 4. Sex

FEMALE WHITE

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

MARRIED

## 6. (b) Name of husband or wife

WILLIAM RAMSEY

## 7. Birth date of deceased (mo., day, yr.)

February 11, 1915

## 6. (c) If alive, give age

36 years

## 8. AGE:

Years 32 Months 11 Days 26 If less than one day  
 hrs. min.

## 9. Birthplace

WEST FAIRVIEW, PA.  
 (Town, county, and state)

## 10. Usual occupation

HOUSEWIFE

## 11. Industry or business

CLINTON ECKERT

## 12. Name

WEST FAIRVIEW, PA.

## 13. Birthplace

MAYBELLE, WALLACE

## 14. Maiden name

PA.

## 15. Birthplace

W. L. Ramsey

## 16. Informant

122 N. Artizan St. Williamsport, Md.

## 17. Burial

Burial Date thereof 2/10/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

## 18. Cemetery or crematory

Rose Hill

## 19. Location

Hagerstown, Md.

## 20. Funeral director

W. J. Horment

## 21. Address

Hagerstown, Md.

## 22. Date rec'd by registrar

Feb 9 48 Registrar Phasell B. Givers

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1948 at 11:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... lo... 19... and that I last saw him... alive on... 19...

## Immediate cause of death

Gunshot wound into skull

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

None

## Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 2/7/48

Where did injury occur? Hagerstown, Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Gunshot wound into skull

Injured at work?

No

DEPUTY MEDICAL EXAM. W. Robert Wells WASH. CO., MD.

23. SIGNATURE W. Robert Wells M. D.

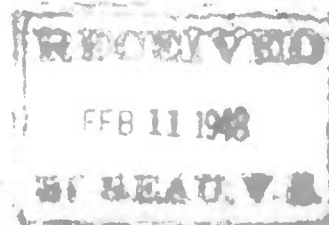
Address Hagerstown, Md. Date signed 2/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct Age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 61

02077

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

## 3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

75

10

12

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

Registrar

20. DATE OF DEATH.....

19.....

at.....

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/1

19.....

to.....

2/10

19.....

48

and that I last saw him alive on.....

2/17

19.....

48

Immediate cause of death.....  
Atherosclerotic Cardio-vascular - renal disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

RECEIVED

FEB 14 1948

51856

ARTISTIAN 20557

SAS 501257

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Frederick  
 City or town..... Emmitsburg, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Parish House  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Rev. Thomas D. Reinhart

3. (b) Social Security Number  
NONE

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) November 9, 1879  
 8. AGE: Years 68 Months 3 Days 12 It less than one day  
 ..... hrs. .... min.

9. Birthplace Cumberland, Maryland  
 (Town, county, and state)  
 10. Usual occupation Priest, St. Anthony's Shrine  
 11. Industry or business Emmitsburg, Maryland  
 12. Name Francis Reinhart  
 13. Birthplace Cumberland, Maryland  
 14. Maiden name Mary E. Downey  
 15. Birthplace Cumberland, Maryland  
 16. Informant George Frey

Address Cumberland, Maryland  
 17. Removal 2-27-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Peter & Paul Cemetery  
 Location Cumberland, Maryland  
 18. Funeral director Lewis Stein, Inc.

Address Cumberland, Maryland  
 19. Feb. 27, 48 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

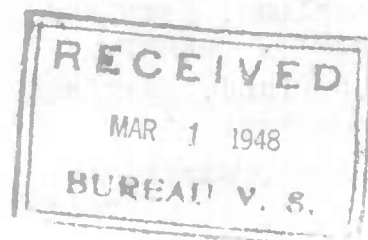
20. DATE OF DEATH Feb. 26, 1948 at 8:30 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... 19..... to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....  
Fractured skull  
 Due to..... Coronary heart disease  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... No  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... accident Date of Feb. 25, 48  
 Where did injury occur? Wash. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Ringold Leifers  
 Means of injury Ran off road Wash. Co. Md.  
 Injured at work? Wash. Co. Md.

23. SIGNATURE S. Robert Wells M. D. Wash. Co. Md.  
 Address Hagerstown Md. Date signed Feb. 27, 48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02078

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County WASHINGTON  
City or town MAUGANSVILLE  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 YRS.  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MARYLAND County WASHINGTON  
City or town MAUGANSVILLE  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war NON-VET.

### 3. (a) FULL NAME

HARVEY EDWARD

### 3. (b) Social Security Number

NONE

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife MARY DIEHL RICE 6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 16, 1881

8. AGE: Years 66 Months 2 Days 11 (If less than one day) hrs. min.

9. Birthplace ANTIRIM TOWNSHIP, FRANKLIN, PA.  
(Town, county, and state)

10. Usual occupation ASST. POSTMASTER

11. Industry or business U.S. POST OFFICE

12. Name DANIEL RICE

13. Birthplace PENNSYLVANIA

14. Maiden name AMANDA SHEELEY

15. Birthplace PENNSYLVANIA

16. Informant Mary D. Rice (wife)

Address Maugansville, Md.

17. Burial Date thereof 3/1/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Greencastle, Pa.

18. Funeral director W. J. Hornum

Address Hagerstown, Md.

19. Feb 28, 48 Registrar Chas. Bowers  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/48 at 10:30 AM  
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb 1 - 48  
and that I last saw him alive on 2/26/48

Immediate cause of death Chronic Endocarditis  
Chronic Nephritis  
arterio-sclerosis

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE V. W. D. Miller  
M. D. or other \_\_\_\_\_  
Address Hagerstown, Md. Date signed 2/28-1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

Dr. V.D. MILLER  
131 W. WASH. ST.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... WASHINGTON  
 City or town... HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 WEEKSHospital, institution, or street address where death occurred:  
24 W. BALTIMORE STREET

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... VIRGINIA County... ROCKINGHAMCity or town... ELKTON  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)2.(a) If veteran, name war... NON-VET. ✓

## 3. (a) FULL NAME

MARY JANE RODGERS

## 3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED.6. (b) Name of husband or wife LEWIS RODGERS7. Birth date of deceased (mo., day, yr.) UNKNOWN 1873 6. (c) If alive, give age... years8. AGE: Years Months Days If less than one day  
74 hrs. min.9. Birthplace... ROCKINGHAM COUNTY, VA.  
(Town, county, and state)10. Usual occupation... HOUSEWIFE

## 11. Industry or business

12. Name... ANDERSON BEASLEY13. Birthplace... VIRGINIA14. Maiden name... MARY ?15. Birthplace... VIRGINIA16. Informant... Grace S. Roach motherAddress... 24 W. Baltimore St.17. Burial Date thereof... 2/14/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Elkton CemeteryLocation... Elkton, Virginia18. Funeral director... W. J. NormentAddress... Hagerstown, Md.19. Feb. 12, 1948 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 11-48 at 5:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6-48 to Feb 11-48 and that I last saw him alive on Feb 10-48Immediate cause of death... stroke following heart DURATION 1 hrDue to... Stroke (12/14/47)Due to... Grand arteriosclerosis 10 yrsOther conditions... 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ....

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 12/14/47Accident, suicide, or homicide... Gunshot Date of 12/14/47Where did injury occur? Home  
(City or town) (County) RockinghamInjured at home, farm, industry, public place (where?) 10 miles from HagerstownMeans of injury fall Injured at work?23. SIGNATURE... S. W. OutleyAddress... Hagerstown, Md. M. D. or other... 7/4/48Date signed... 7/4/48



RECEIVED

FEB 14 1948

ECHEA V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... WASHINGTONCity or town... HAGERSTOWN  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 YRS.

Hospital, institution, or street address where death occurred:

144 FAIRGROUND AVE.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... WASHINGTONCity or town... HAGERSTOWN  
(If outside city or town limits, write RURAL and give nearest town)Street No. 144 FAIRGROUND AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war... NON-VET.

## 3. (a) FULL NAME

CHRISTIAN ALBERT RYERSON

## 3. (b) Social Security Number

214-09-0239

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife... MAY S. RYERSON(SAMPLE)7. Birth date of deceased (mo., day, yr.) DECEMBER 1, 18956. (c) If alive, give age 45 years

8. AGE: Years Months Days If less than one day

52 2 28 hrs. min.9. Birthplace... NORWAY

(Town, county, and state)

10. Usual occupation... TOOL MAKER11. Industry or business... FURNITURE FACTORY12. Name... EILERT RYERSON13. Birthplace... NORWAY14. Maiden name... ANNA PAULSEN15. Birthplace... NORWAY16. Informant... May S. Ryerson (Wife)Address... 144 Fairground Ave17. Burial Date thereof... 3/3/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rose HillLocation... Hagerstown, Md.18. Funeral director... W. J. FlormontAddress... Hagerstown, Md.19. Mar 26 1948 Chas H Bowers

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 29 1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him... alive on... 19... 19...

Immediate cause of death... DURATION

Acute coronary occlusion

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... NoneAutopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of...

Where did injury occur? (City or town) (County) (State)

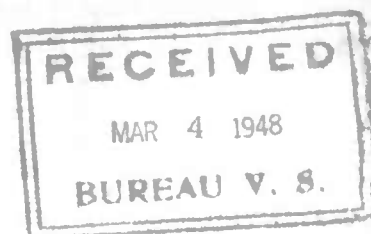
Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

DEPUTY MEDICAL EXAM.

23. SIGNATURE... Robert Meeks WASH. CO., MD.Address... Hagerstown, Md. Date signed... 3/1/48

Dr. Wells  
115 N. Patomac St.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02082

Reg. Dist. No. 302

1. PLACE OF DEATH:  
 County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (The newborn infant give residence of mother)  
 State... West Va. County... Jefferson  
 City or town... Shepherdstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None ✓

3. (a) FULL NAME John Boone Schley, Jr.

3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) August 28, 1945 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Year 2 Month 5 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown, Washington, Md.  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name John Boone Schley

13. Birthplace Shepherdstown, West Va.

14. Maiden name John White Snyder

15. Birthplace Shepherdstown, West Va.

16. Informant Mrs. John B. Schley

Address Shepherdstown, West Va.

17. (Burial, cremation, or removal) Which? Burial Date thereof 2/23/48  
 (month) (day) (year)

Cemetery or crematorium Elmwood Cemetery

Location Shepherdstown, West Va.

18. Funeral director Charles Town, West Va.

Address Charles Town, West Va.

19. Feb. 20, 48 Registrar Charles Town, West Va.  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1948 at 6:35 A.M.

21. I CERTIFY that death occurred on the date above related; that I attended deceased from February 19, 1948 to Feb 20, 1948 and that I last saw him alive on Feb 20, 1948

Immediate cause of death Respiratory Failure

Due to Methyl salicylate

Due to intoxication

Due to Ingestion of oil of wintergreen (file 148-a-6)

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Elizabeth L. Linn M. D. or other \_\_\_\_\_

Address 214 N. Potomac St., Hagerstown Date signed 2-20-48

RECEIVED

FEB 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells 02083

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 S. Mulberry St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Christ Scouropanos

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

-----

7. Birth date of

deceased (mo., day, yr.)

January 10, 1880

6. (c) If alive, give age ----- years

8. AGE:

Years

Months

Days

If less than one day

6715

hrs.

min.

9. Birthplace

Theodorina, Greece

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Restaurant

FATHER

12. Name

John Scouropanos

13. Birthplace

Greece

MOTHER

14. Maiden name

No Record

15. Birthplace

No Record

16. Informant

Louis Scouropanos

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/18/48  
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Washington Co., Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

Feb. 16, 48  
(Date rec'd by registrar)

19.

[Signature]  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 19 48 at 5:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr/193719 48 to 19 48and that I last saw him alive on Feb/15/48 19 48

Immediate cause of death

DURATION

chr. bronchial asthma20 yrsDue to Urethral strictures20 yrschr. myocarditis5 yrs

Due to

acute ventricular fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. Robert Wells, M.D.

M. D. (Print name)

Address Hagerstown, Md. Date signed 2/16/48

RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Di 02084

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Maugansville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 Years  
 Hospital, institution, or street address where death occurred:  
North St.  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Maugansville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. North St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

NOAH S. SHANK

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Grace V. Shank  
 6.(c) If alive, give age 70 years  
 7. Birth date of deceased (mo., day, yr.) August 8, 1875  
 8. AGE: Years 72 Months 5 Days 26 If less than one day  
hrs. min.

9. Birthplace Leitersburg, Washington Co., Md.  
 (Town, county, and state)

10. Usual occupation Farmer11. Industry or business Retired12. Name Jonas Shank13. Birthplace Leitersburg Md.14. Maiden name Mantha E. Swartz15. Birthplace Gettysburg Pa.16. Informant Miss Clara E. ShankAddress Washington D.C.

17. Burial Date thereof 2/7/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Church of The Brethern Cen.Location Broadfording Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.

19. Feb. 7, 48  
 (Date rec'd by registrar) Registrar W. H. Howard

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1948 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-1-47 to Feb 4  
 and that I last saw him alive on Feb 4-48

Immediate cause of death

DURATION

Ch. Myocarditis3 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md Date signed 2/7/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02085

93d

## 1. PLACE OF DEATH:

County WashingtonCity or town Ravenwood  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

Hagerstown md. R.3.How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Ravenwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. Hagerstown md. R.3

(If rural, give LOCATION)

2.(a) If veteran, name war no.

## 3. (a) FULL NAME

Sarah Ellen Shank

## 3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Oliver J. Shank

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

85017

hrs.

min.

9. Birthplace

Dred. Co. Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

own home

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial -

Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 3, 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 February 1948 at 11:45 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1 February 1948 to Post mortemand that I did not see her alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Cardiac failure

Due to

Hypertensive cardiovascular

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

No operations

Date of op. \_\_\_\_\_

Autopsy results

Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Robert T. Keadle, M.D.

M. D. or other

Address

132 W. Wash StDate signed 3 Feb 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS AN5

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02086 202

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? our Year

Hospital, institution, or street address where death occurred:

# 8 East Washington St Hagerstown Md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war 20

## 3. (a) FULL NAME

Mrs. Hilda B. Shayer

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Don O ShayerMay 7 - 1923 6. (c) If alive, give age 27 years7. Birth date of deceased (mo., day, yr.) May 7 - 1923

8. AGE: Years Months Days If less than one day

24 9 4 hrs. min.9. Birthplace Ft Landon Pa.  
(Town, county, and state)10. Usual occupation Home work

11. Industry or business

12. Name Charles Byers13. Birthplace Richmond Furnace Pa.14. Maiden name Pearl Armstrong St Thomas Pa.15. Birthplace St Thomas Pa.16. Informant Don O ShayerAddress St Thomas Pa17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof Feb. 14 - 48  
(month) (day) (year)Cemetery or crematory St Thomas Pa.Location St Thomas Cemetery Pa19. Funeral director D. J. Linniger & SonAddress Mercersburg Pa.20. Date signed Feb. 11. 194821. Signature G. H. Shayer22. Address Hagerstown Md23. Date signed 2/11/48

24. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1948 at 11:30 A. M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

February 6 1948 to February 11 1948and that I last saw him alive on February 11 1948

Immediate cause of death

Pulmonary tuberculosisSecondary pulmonaryhemorrhage

DURATION

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. J. Linniger & SonAddress Hagerstown MdDate signed 2/11/48

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

RECEIVED

FEB 13 1948

FT. BELLEVILLE

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02087

Reg. Diat. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life Resident  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 60 Madison Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Nettie Lou Showe

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 5, 1881 8.(c) If alive, give age years

8. AGE: Years 66 Months 6 Days 26 If less than one day hrs. min.

8. Birthplace Washington County, Md.  
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Harm Showe

13. Birthplace Washington County, Md.

14. Maiden name Amanda Wilkinson

15. Birthplace Washington County, Md.

16. Informant Mrs. Lela Lynch

Address Mercersburg, Pa.

17. Burial Date thereof Feb. 5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

18. Feb. 5, 48 (Date rec'd by registrar) Registrar W. H. Howard

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1948 19 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1948 to February 2, 1948 and that I last saw him alive on February 2, 1948

Immediate cause of death Tuberculous Pericarditis  
Tuberculous Pleurisy with  
effusion

Other conditions None

Major findings of operations none

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

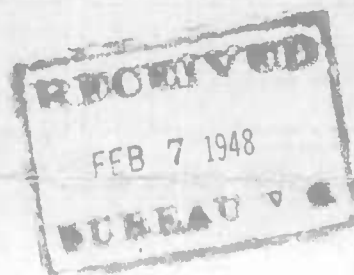
Means of injury Injured at work?

23. SIGNATURE Arthur Robert Cohen M. D. 2-13-48  
Address Clear Spring, Md. Date signed 2/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Hochlander

Reg. Dist. No. 02488

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Years  
 Hospital, institution, or street address where death occurred:  
251 Mulberry St.  
 How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 251 Mulberry St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS ANNIE MISSOURI SMITH

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Clinton R.  
 7. Birth date of deceased (mo., day, yr.) July 23, 1882 6.(c) If alive, give age 68 years  
 8. AGE: Years 65 Months 6 Days 15 It less than one day hrs. min.

9. Birthplace Detour, Carroll Co. Md.  
 (Town, county, and state)  
 10. Usual occupation House Wife  
 11. Industry or business Own Home  
 12. Name David Six  
 13. Birthplace Detour, Md.  
 14. Maiden name Mollie Hollenberry  
 15. Birthplace Detour, Md.

16. Informant Clinton R. Smith  
 Address Hagerstown Md.  
 17. Burial Burial Date thereof 2/11/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Feb. 11, 48 Chas. H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 19 48 at 940 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Feb 19 48  
death on arrival 19 48  
 and that I last saw him alive on 19 48

Immediate cause of death Coronary Heart Disease  
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. H. Hochlander M. D. or otherAddress 4 agentum 2nd Date signed 2/19/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

### 1. PLACE OF DEATH:

County Wash

City or town Leantown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wash

City or town Leantown md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war none

### 3. (a) FULL NAME

Estimide May Smith

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife none

7. Birth date of deceased 10 mo, day, yr

5. (c) If alive, give age none years

8. AGE: Years 79 Months 11 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Near Wagsville, Fred Co md  
(Town, county, and state)

10. Usual occupation Housekeeping

11. Industry or business

12. Name John I. Sisson

13. Birthplace Near Wagsville, Fred Co md

14. Maiden name Matilda Pline

15. Birthplace Near Wagsville, Fred Co md

16. Informant Belva French

Address Leantown md

17. Burial Burial Date thereof 3-2-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Leantown

Location Leantown md

18. Funeral director Geo. B. Hoover

Address Smithsburg md

19. Mar 12 1948 Geo W. Ferguson  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1948 to Feb 29 1948  
and that I last saw him alive on Feb 29 1948

Immediate cause of death

Pulmonary Edema 14 hrs

Due to Decompensated Heart 30 days

Due to Arterio Sclerosis 10 yrs

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE E. G. S. O'Leary M. D. or other

Address Smithsburg md Date signed 3/1/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Stagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 wks  
Hospital, institution, or street address where death occurred:  
Washington Co Hospital  
How long in hospital or institution? 7 wks

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Pa County Franklin  
City or town RID # 2  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Greencastle  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3.(a) FULL NAME

NINA ALICE SNIDER

### 3.(b) Social Security Number

NONE

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced married

8.(b) Name of husband or wife Samuel Snider

7. Birth date of deceased (mo., day, yr.) July 6, 1888 6.(c) If alive, give age 60 years

8. AGE: Years 59 Months 7 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Antwerp, Ohio  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name James F. Snider

13. Birthplace Adams Co, Pa

14. Maiden name Susan Bender

15. Birthplace Williamson Pa

16. Informant Samuel S. Snider

Address Greencastle RD #2

17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb 13/48  
(month) (day) (year)

Cemetery or crematory Montgomery

Location near Welsh Run, Pa

18. Funeral director DeMunnich

Address Greencastle Pa

19. Feb 12, 1948 Registrar Chas H Howard

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 48 at 10:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 February 1947 to 10 Feb 1948 and that I last saw her alive on 10 February 1948

Immediate cause of death Carcinoma of gall bladder  
chronic DURATION 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations Ca of gall bladder with liver metastases Date of op. 29 Oct 47

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William G. Snider M. D. or other MD

Address Greencastle, Pa Date signed 10 Feb 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTESIAN WATER

NO CONTENT

RECEIVED

FEB 14 1948

BLERAY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Zimmerman

02091

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 Years  
 Hospital, institution, or street address where death occurred:  
9 Roessner Ave  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9 Roessner Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

ROBERT BRUCE SNYDER

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife Mahala  
 6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) January 4 1871

8. AGE: Years 77 Months 1 Days 4 It less than one day hrs. min.

9. Birthplace Hagerstown Wash. Co. Md.  
 (Town, county, and state)

10. Usual occupation Time Keeper

11. Industry or business W.M.R.R.

12. Name John B. Snyder

13. Birthplace Leitersburg Md.

14. Maiden name Elizabeth H. Trovinger

15. Birthplace Leitersburg Md.

16. Informant Robert B. Snyder Jr.

Address Hagerstown Md.

17. Burial Rest Haven Cemetary Date thereof 2/24/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hagerstown Md.

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 22, 48 Registrar W. H. Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22 19 48 to Feb. 22 19 48

and that I last saw him alive on Feb. 22 19 48

Immediate cause of death Cerebral Arteriosclerosis

DURATION

30 min

Due to Arteriosclerosis

Due to Arteriosclerosis

2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Zimmerman M. D. or other

Address W. H. Bowers Date signed 2/23/48

RECEIVED

FEB 26 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02092

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
906 Lanvale St.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 906 Lanvale Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Shirley Rey Stains

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) November 27, 19478. AGE: Years 0 Months 2 Days 24 If less than one day  
..... hrs. .... min.9. Birthplace Hagerstown Wash. Co. Maryland  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Harry M. Stains  
 13. Birthplace..... Greencastle, Penna.  
 MOTHER 14. Maiden name..... Doris L. Eckstine  
 15. Birthplace..... Hagerstown, Maryland

16. Informant..... Mr. Harry M. Stains  
 Address..... 906 Lanvale St. Hagerstown, Md.

17. Burial Date thereof..... Feb. 20, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Rose Hill Cemetery  
 Location..... Hagerstown, Maryland

18. Funeral director..... Fred W. Kraiss  
 Address..... Hagerstown, Maryland

19. Feb. 21, 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1948 at..... A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 17, 1948 to February 18, 1948  
 and that I last saw him alive on February 17, 1948

Immediate cause of death Pneumonia, Bronchial

DURATION

16 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. J. Layman, M.D.  
 Address..... Hagerstown, Md. M. D. or other  
 Date signed..... 20 Feb 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

*For information*

RECEIVED  
FEB 24 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

02093

302

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred..... <u>Washington Co. Hosp.</u> How long in hospital or institution?..... <u>3 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For new-born infants give residence of mother) State..... <u>Penn.</u> County..... <u>Franklin</u> City or town..... <u>Mercersburg</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) ✓ 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Miss Mary E. Steiger</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Single</u>		<b>MEDICAL CERTIFICATION</b>	
<b>B. (b) Name of husband or wife</b> .....		<b>6. (c) If alive, give age</b> ..... years		<b>2D. DATE OF DEATH</b> ..... <u>Feb. 3,</u> 19 <u>48</u> at <u>10:45<sup>a</sup></u> M.		<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Feb. 1</u> 19 <u>48</u> to <u>Feb 3</u> 19 <u>48</u> and that I last saw her alive on <u>Feb 3</u> 19 <u>48</u> .	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 19, 1870</u>		<b>8. AGE:</b> Years <u>77</u> Months <u>8</u> Days <u>4</u> If less than one day..... hrs. .... min.		<b>Immediate cause of death</b> <u>Uremia</u>		<b>DURATION</b> <u>3 days</u>	
<b>9. Birthplace</b> ..... <u>Mercersburg, Pa.</u> (Town, county, and state)		<b>10. Usual occupation</b> ..... <u>Housekeeper</u>		<b>Due to</b> ..... <u>Hypertensive Cardio-vascular Disease</u>		<u>unknown</u>	
<b>11. Industry or business</b> .....		<b>12. Name</b> ..... <u>Geo. C. Steiger</u>		<b>Other conditions</b> ..... <u>Urethrococle</u> <u>gangrene</u> (Include pregnancy within 3 months of death)		<u>2 wks</u> <u>1 wk</u>	
<b>13. Birthplace</b> ..... <u>Germany</u>		<b>14. Maiden name</b> ..... <u>Catherine Reiser</u>		<b>Major findings of operations</b> ..... <u>None</u>		<b>Date of op.</b> .....	
<b>15. Birthplace</b> ..... <u>S. S. Steiger</u>		<b>16. Informant</b> ..... <u>Mercersburg, Pa.</u> Address.....		<b>Autopsy results</b> ..... <u>None</u>		<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.	
<b>17. Burial</b> ..... <u>Funerary Co.</u> (Burial, cremation, or removal. Which?) Date thereof..... <u>2/6/48</u> (month) (day) (year) Cemetery or crematory..... <u>Mercersburg, Pa.</u> Location..... <u>The Steiger</u>		<b>18. Funeral director</b> ..... <u>Mercersburg, Pa.</u> Address.....		<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....		<b>23. SIGNATURE</b> ..... <u>Richard V. Hanner</u> <u>Hagerstown, Md.</u> M. D. or other Address..... Date signed..... <u>2/3/48</u>	
<b>19. (Date rec'd by registrar)</b> ..... <u>Feb 3, 48</u>		<b>Registrar</b> ..... <u>Blackbourn</u>					

RECEIVED

RECEIVED

RECEIVED  
FEB 5 1948  
FEB 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Hornbaker

Reg. Dist. No. 02091

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Week  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 Week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 455 West Antietam St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS CARRIE MAY STONER

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Edward B. Stoner  
 7. Birth date of deceased (mo., day, yr.) July 2, 1886  
 6.(c) If alive, give age 62 years

8. AGE: Years 61 Months 5 Days 7 If less than one day  
 hrs. min.

9. Birthplace Greencastle, Franklin Co. Pa.  
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own Home

12. Name Upton Easton

13. Birthplace Upton Pa.

14. Maiden name Rebecca Lily

15. Birthplace Richmond Furnace Pa.

16. Informant Howard E. Stoner

Address Ridgley, West Virginia

17. Burial Date thereof 2/11/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb. 11, 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12/10/47 1947, to 2-9-1948  
 and that I last saw her alive on 2/8 1948

Immediate cause of death

Thrombosis of Superior Mesenteric  
Artery & gangrene of bowel  
 Due to hypertensive-arteriosclerotic  
cardiovascular disease

Due to

Other conditions arterial embolus left lower leg  
1cc  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Hornbaker M.D.  
 M. D. or other

Address 154 W. Washington St. Hagerstown Md. Date signed 2/9/48



Evidence for change of  
year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

02095

301

FILM No. G 114 MAR 9 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington

City or town RURAL-Williamsport, RFD#2  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:  
Williamsport, Md. RFD#2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington

City or town RURAL-Williamsport,  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Williamsport, Md. RFD#2  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Lester Clyde Syster

3.(b) Social Security Number

236-12-8956

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1887 / 1897

8. AGE:

Years

Months

Days

If less than one day

50

5

26

hrs.

min.

9. Birthplace

Falling Waters, Berkeley, W. Va.  
(Town, county, and state)

10. Usual occupation

Carpenter  
Building

11. Industry or business

FATHER

12. Name

John Syster

13. Birthplace

Falling Waters, W. Va.

MOTHER

14. Maiden name

Nettie Byron

15. Birthplace

Pennsylvania.

16. Informant

Mrs. Harry Rupp  
Williamsport, Md. RFD#2  
Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof March 1, 1948  
(month) (day) (year)

Cemetery or crematory

Harmony Cemetery

Location

Marlowe, West Virginia.

18. Funeral director

Mrs. Edith V. Leaf

Address

Williamsport, Md.

19.

3/1 19 48  
(Date rec'd by registrar)

Mrs. E. Lee M. Elroy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/27/48

19

3:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/27/48 19 2/27/48 19  
and that I last saw him alive on 2/27/48 19

Immediate cause of death

Cranial Occlusion

Duration

Chronic etc

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

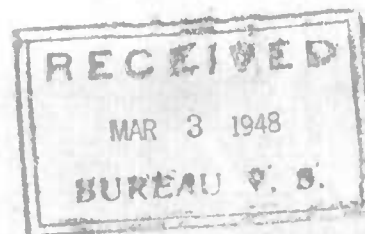
23. SIGNATURE

P. F. Young  
Address Williamsport, Md. Date signed 2/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town SAN MAR  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 YRS 8 MOS.  
 Hospital, institution, or street address where death occurred:  
FAHRNEY MEMORIAL HOME  
 How long in hospital or institution? 4 YRS 8 MOS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County FRANKLIN  
 City or town WAYNESBORO  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2 PHILADELPHIA AVE  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war ✓

## 3. (a) FULL NAME

SUZANNE THOMPSON

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) MARCH 12 1857 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 90 Months 11 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace MT. ALTO, PENNA.  
 (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name JACOB WOOLRIDGE13. Birthplace MT. ALTO, PENNA.14. Maiden name UNKNOWN15. Birthplace MT. ALTO, PENNA.16. Informant NEVIN THOMPSONAddress 2 PHILA. AVE., WAYNESBORO, PA.

17. BURIAL Date thereof MARCH 2 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GREEN HILLLocation WAYNESBORO, PENNA.18. Funeral director R. S. EganAddress Kedysmith - Md19. Nov. 28, 48 19 48 John H. Bast

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 19 48 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 19 48 to Feb. 28 19 48  
 and that I last saw him alive on Feb. 27 19 48

Immediate cause of death

Chronic MyocarditisDue to atherosclerotic gangreneDue to of both legs

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. W. L. Way M.D.Address Baltimore, Md Date signed Feb. 28, 48



CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF CEMETERY OFFICIAL

19. SIGNATURE OF OTHER OFFICIAL

20. SIGNATURE OF OTHER OFFICIAL

RECEIVED

MAR 3 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

02097

94a

### 1. PLACE OF DEATH

County **Washington**  
City or town **Hagerstown**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **14 years**  
Hospital, institution, or street address where death occurred:  
**Washington County Hospital**  
How long in hospital or institution? **1 hour**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State **Maryland** County **Washington**  
City or town **Hagerstown**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **1006 Hamilton Blvd.**  
(If rural, give LOCATION)  
2. (a) If veteran, name war. **-----**

### 3. (a) FULL NAME

**John C. Trace**

### 3. (b) Social Security Number

**717-07-9340**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**

6. (b) Name of husband or wife **Mary S. Trace**  
6. (c) If alive, give age **52** years

7. Birth date of deceased (mo., day, yr.) **July 30, 1887**

8. AGE: Years **60** Months **6** Days **19** If less than one day **hrs. min.**

9. Birthplace **Near Greencastle Franklin Pa.**  
(Town, county, and state)

10. Usual occupation **Telegraph Operator**  
11. Industry or business **Pa. R.R.**

12. Name **Frank Trace**  
13. Birthplace **New Franklin Pa.**

14. Maiden name **Emma K. Shrader**  
15. Birthplace **Myersville Md.**

16. Informant **Mrs Mary S. Trace**  
Address **Hagerstown Md.**

17. **Burial** Date thereof **Feb. 22- 1948**  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory **Green Hill Cemetery**  
**Martinsburg W. Va.**

Location **Scott F. Minnich & Son**  
**Hagerstown Md.**

18. Funeral director **Scott F. Minnich & Son**  
Address **Hagerstown Md.**

19. **Feb. 21, 48** Registrar **W. H. Hower**  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH **February 19 1948** at **9:42p.m.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **2/16/48** to **2-19-48** and that I last saw him alive on **2-19-48**

Immediate cause of death **Coronary Occlusion** 2/16/48

Due to **Coronary Occlusion**

Due to **Coronary Occlusion**

Other conditions **Coronary Occlusion**

(Include pregnancy within 8 months of death)

Major findings of operations **Coronary Occlusion**

Autopsy results **Coronary Occlusion**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide **Coronary Occlusion** Date of **2/16/48**

Where did injury occur? **Coronary Occlusion** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **Coronary Occlusion**  
Means of injury **Coronary Occlusion** Injured at work? **Coronary Occlusion**

23. SIGNATURE **W. H. Hower** M. D. or other **W. H. Hower**  
Address **W. H. Hower** Date signed **2/20/48**

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 24 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
101 Madison Avenue  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 101 Madison Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Joseph Valentine

## 3. (b) Social Security Number

706-10-6250

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 8.(b) Name of husband or wife Elizabeth Valentine 6.(c) If alive, give age 72 years  
 7. Birth date of deceased (mo., day, yr.) July 25, 1888  
 8. AGE: Years 59 Months 6 Days 10 It less than one day  
 hrs. min.

9. Birthplace Italy (Town, county, and state)  
 10. Usual occupation Trackman  
 11. Industry or business Western Maryland R.R.  
 12. Name Patsy Valentine  
 13. Birthplace Italy  
 14. Maiden name Rosie  
 15. Birthplace Italy

16. Informant Mrs. Joseph Valentine  
 Address Hagerstown, Maryland  
 17. Burial Date thereof 2-7-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland  
 18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. Feb. 6, 48 Charles Howard  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1948 at 5:48  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 - 1947 to Feb 4 - 1948  
 and that I last saw him alive on Feb 3 1948

Immediate cause of death Cirrhosis (asplenic) of Liver  
 Due to.....  
 Due to.....  
 Other conditions Abdominal Aortic  
 (Include pregnancy within 3 months of death)  
 Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Charles Howard M.D. or other  
 Address Hagerstown Md Date signed 2/4/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02099

302

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town RURAL HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? LIFE  
 Hospital, institution, or street address where death occurred:  
HAGERSTOWN R.F.D.# 6  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County WASHINGTON  
 City or town RURAL HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. HAGERSTOWN R.F.D.# 6  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war NON-VET.

## 3. (a) FULL NAME

ANNA M. WEBER

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED  
 6. (b) Name of husband or wife BENJAMIN B.  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) NOVEMBER 30, 1872

8. AGE: Years 75 Months 2 Days 4 hrs. \_\_\_\_\_ min.  
 9. Birthplace CLEARSPRING, WASH., MD.  
 (Town, county, and state)  
 10. Usual occupation HOUSEWIFE

## 11. Industry or business

12. Name M. H. MARTIN  
 13. Birthplace LANCASTER COUNTY, PA.  
 14. Maiden name MARY HEGE  
 15. Birthplace CHAMBERSBURG, PA.

16. Informant John S. Weber  
 Address Hager R.F.D.# 6

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 2/6/48  
 (month) (day) (year)

Cemetery or crematory Reiff Cemetery  
 Location Washington County, Md.

18. Funeral director W. J. Hornum  
 Address Hagerstown, Md.

19. Feb. 4, 1948 Registrar Charles H. Brown  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1948 at 8:20 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28-48 to Feb 4-48  
 and that I last saw Feb 3-48 alive on Feb 3-48

Immediate cause of death \_\_\_\_\_  
Senility  
 Due to \_\_\_\_\_  
General arteriosclerosis  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

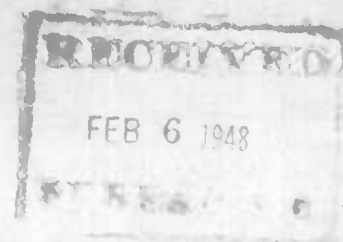
Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. Hornum M. D. or other \_\_\_\_\_  
 Address Hagerstown, Md. Date signed 2/4/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02100

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**  
County.....**Hagerstown**  
City or town.....**4 months**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
**Washington County Hospital**  
How long in hospital or institution?.....**2 months**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....**Maryland** County.....**Washington**  
City or town.....**Boonesboro Rural Rt. 2**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

**Terry A. Weigand**

### 3. (b) Social Security Number

---

4. Sex.....**Male**  
5. Color or race.....**White**  
6.(a) Single, married, widowed, or divorced.....**Single**  
6.(b) Name of husband or wife.....  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....**October 17, 1947**  
8. AGE: Years..... Months..... Days.....  
**4**.....**10**.....**hrs.**.....**min.**

9. Birthplace.....**Hagerstown Wash. Md.**  
(Town, county, and state)  
10. Usual occupation.....**None**  
11. Industry or business.....**None**  
FATHER 12. Name.....**Donald C. Weigand**  
13. Birthplace.....**Leitersburg Md.**  
MOTHER 14. Maiden name.....**Frances Ritenour**  
15. Birthplace.....**Hagerstown Md.**

16. Informant.....**Donald C. Weigand**  
Address.....**Boonesboro Rt. 2**

**Burial**.....**Feb. 28, 1948**  
(Burial, cremation, or removal. Which?).....  
Cemetery or crematory.....**Rose Hill Cemetery**  
**Hagerstown Md.**  
Location.....

18. Funeral director.....**Scott F. Minnich & Son**  
Address.....**Hagerstown Md.**

19. **Feb. 28. 48**.....**Blanch Bowers**  
(Date rec'd by registrar)..... Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....**February 27**.....**19 48**.....**5:45p**.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**Oct 17 -**.....**19 47**.....**to Feb 27**.....**19 48**  
and that I last saw him alive on.....**Nov 22**.....**19 47**

Immediate cause of death.....**Congenital Heart Disease**  
**Congenital disease of**  
**Stentary (Anomaly)**  
Duo to.....**11 11**

Duo to.....  
Other conditions.....**Terminal Broncho -**  
**Pneumonia**  
(Include pregnancy within 8 months of death)

Major findings of operations.....  
**Patent ductus arteriosus**.....Date of op.....  
Autopsy results.....**Small Pulmonary - Scent - Broncho - Pneumonia**  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?.....  
(City or town)..... (County)..... (State).....  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?

23. SIGNATURE.....**Edney Hovestad MD**  
Address.....**Leitersburg Md**..... Date signed.....**2/28/48**  
M. D. or other

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

02101

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 hour

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 129 West Church Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Frank Welcham

## 3. (b) Social Security Number

220-09-9051

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Not Known 1883 6. (c) If alive, give age..... years

8. AGE: Years 65 Months 0 Days 0 If less than one day  
 hrs. 0 min. 0

9. Birthplace Missouri  
 (Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

12. Name Not Known

13. Birthplace Not Known

14. Maiden name Not Known

15. Birthplace

16. Informant Ada Carey

Address Hagerstown, Maryland

17. Burial Date thereof 2-28-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bellevue

Location Hagerstown, Maryland

18. Funeral director William Downey

Address Hagerstown, Maryland

19. Feb. 28 19 48 Charles H. Boward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Feb 19 48 at 10:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 Sept 19 48, to 24 Feb 19 48

and that I last saw him alive on 24 Feb 19 48

Immediate cause of death Cerebral hemorrhage

DURATION

6 hrs.

Due to.....

Due to.....

Other conditions Hypertension, secondary

vascular renal disease

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Edna D. H. Boward M.D.

M. D. or other

Address Hagerstown Md Date signed 2/27/48

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Kniesly

02103

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 Hours  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 12 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 930 Pope Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Unnamed Twin of Andrew McC White

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 8. (b) Name of husband or wife

--

## 7. Birth date of

deceased (mo., day, yr.)

February 13 1948

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

------12 hrs.29 min.

## 9. Birthplace

Hagerstown Washington Co. Md.  
(Town, county, and state)

## 10. Usual occupation

---

## 11. Industry or business

MOTHER FATHER

## 12. Name

Andrew McC. White

## 13. Birthplace

Hagerstown Md.

## 14. Maiden name

Thelma V. Spence

## 15. Birthplace

Sharpsburg Md.

## 16. Informant

Andrew McC. White

## Address

Hagerstown Md.

## 17.

Burial

## Date thereof

2/16/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Hagerstown Md.

## 18. Funeral director

Andrew K. Coffman

## Address

Hagerstown Md.

## 19.

Feb. 16. 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 48 at 11:34P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1319 48, toFebruary 13 19 48and that I last saw her alive on February 13, 19 48Immediate cause of death Pre-maturity

DURATION

Due to Mother 5 1/2 months pregnant

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 148 W. Washington Street Date signed 2-16-48

RECEIVED

FEB 18, 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Kniesly

02192  
Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Day  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 930 Pope Avenue  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war None

## 3. (a) FULL NAME

THELMA MA MAE  
Unamed Child of Andrew McC. White

Twin #1

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

---

## 7. Birth date of

deceased (mo., day, yr.)

February 13, 1948

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

--

--

1

hrs.

min.

## 9. Birthplace

Hagerstown Washington Co. Md.  
 (Town, county, and state)

## 10. Usual occupation

Infant

## 11. Industry or business

FATHER  
 MOTHER

## 12. Name

Andrew McC. White

## 13. Birthplace

Hagerstown Md.

## 14. Maiden name

Thelma V. Spence

## 15. Birthplace

Hagerstown Md.

## 16. Informant

Andrew McC. White

## Address

Hagerstown Md.

## 17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

2/16/48

(month) (day) (year)

## Cemetery or crematory

Rose Hill Cemetery

## Location

Hagerstown Md.

## 18. Funeral director

Andrew K. Coffman

## Address

Hagerstown Md.

## 19.

Feb. 16, 1948  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948 at 7:10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 13 1948 to February 14 1948

and that I last saw her alive on February 14 1948

Immediate cause of death

Pre-maturity

DURATION

Due to

Mother 5; 1/2 months pregnant

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

M. D. or other

Address

148 W. Washington St.

Date signed 2-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 02104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County WashingtonCity or town Brethedsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland State Reformatory for Males

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. No Record

(If rural, give LOCATION)

2. (a) If veteran, name war No Record

## 3. (a) FULL NAME

Oscar Williams

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

---6. (c) If alive, give age --- years

7. Birth date of

Deceased (mo., day, yr.)

November 6, 1915

8. AGE:

Years

Months

Days

If less than one day

32319hrs.min.9. Birthplace Ft. Lauderdale, Broward Co. Fla.  
(Town, county, and state)

10. Usual occupation

No Record

11. Industry or business

No RecordFATHER  
MOTHER

12. Name

Calvin Williams

13. Birthplace

No Record

14. Maiden name

Louise Williams

15. Birthplace

No Record16. Informant Records Md. St. Ref. For Males

Address

Brethedsville Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/28/48

(month) (day) (year)

Cemetery or crematory

Md. St. Reformatory Cemetery

Location

Brethedsville Maryland

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.19. Feb 27, 48

(Date rec'd by registrar)

John H. Bask

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1948 at 5:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 16 19 48, to Feb 25 19 48  
and that I last saw him alive on Feb 24 19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.

M. D. or other

Address

Hagerstown, Md.

Date signed

2-25-48



RECEIVED

MAR 3 1948

BUREAU V. 2.

Birth and Death  
161a 82302

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Washington  
City or town Fredericktown  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
Washington County Hospital  
Length of mother's stay in County 0  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State Maryland  
County Fredrick  
City or town (near) Wolfsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 1, Smithsburg, Md.  
(If RURAL give LOCATION) ✓

3. Name of child Baby Boy Wolfe  
5. Sex Male | 6. Twin or triplet

4. Date of birth 2/8 19 48 Hour 11:53 P.M.  
7. No. of weeks pregnancy 40 weeks

**FATHER OF CHILD**

8. Full name Robert Guy Wolfe  
9. Color White 10. Age at time of this birth 49 yrs.  
11. Usual occupation Unemployed at present

**MOTHER OF CHILD**

12. Full maiden name Della Mae Lewis  
13. Color White 14. Age at time of this birth 39 yrs.  
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 6  
(b) How many other children were born alive but are now dead? 3 (c) How many other children were born dead? 1

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Edema & hypertension or albuminuria

19. Labor: (a) Complications of None  
(b) Induced? No

20. (a) Was there an operation for delivery? No (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? —  
During operation? —

23. (a) Burial (b) Date thereof Feb. 12, 1948  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Bethel Cemetery

24. (a) Funeral director First W. Sears  
(b) Address Fredericktown, Maryland

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Atelectasis, Congenital  
(b) Maternal causes None

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature Robert F. Keagle  
(Specify if M. D., midwife, or other)

Address 132 N. Wash St.

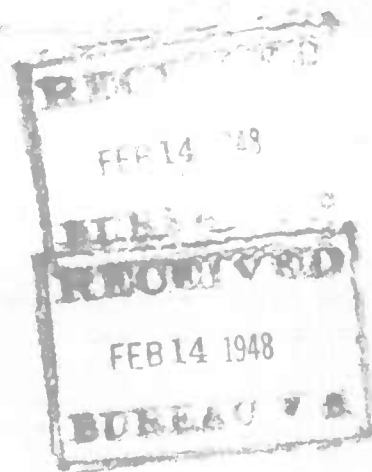
25. (a) Feb. 13, 1948 (b) Charles H. Powers  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per.....

\* See Instruction C on stub.

Child lived, 39 minutes



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

EVIDENCE FOR CHANGE OF #661501  
FILM # 9119 - 3-14-49

## CERTIFICATE OF DEATH

Reg. Diat. No. 02106

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Hagerstown Md. R. 2  
at home  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Hagerstown Md. R. 2  
(If rural, give LOCATION)  
2. (a) If veteran, name war no

## 3. (a) FULL NAME

Lee A. Wolfkill

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Marie & Mary J.  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) June - 29 - 1898  
8. AGE: Years 49 Months 7 Days 24 hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown Md.  
(Town, county, and state)  
10. Usual occupation Burial Vault mfg.  
11. Industry or business

FATHER  
12. Name John B. Wolfkill  
13. Birthplace Hagerstown Md.  
MOTHER  
14. Maiden name Lula Grossnickle  
15. Birthplace Mapleville Md.

18. Informant Mrs. Naomi E. Wolfkill  
Address Hagerstown Md.

17. Burial Date thereof Feb. 26, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Location Hagerstown Md.

18. Funeral director Clara J. Best & Sons  
Address Boonsboro Md.

19. Feb. 25 - 1948 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1948 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11, 1947 to February 23, 1948  
and that I last saw him alive on February 23, 1948

Immediate cause of death  
Chronic sclerotic heart disease -

## DURATION

3 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Vascular hypertension -  
Generalized arteriosclerosis  
(Include pregnancy within 3 months of death)

3 yearsMajor findings of operations None

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Dr. J. M. ...

Address Hagerstown Md. Date signed Feb 25, 1948  
M. D. Registrar

RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Hirshman

02107

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Hours  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 10 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1803 Virginia Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

EDMUND WALTER WYAND

## 3. (b) Social Security Number

214-09-7156

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Geist  
 6. (c) If alive, give age 35 years  
 7. Birth date of deceased (mo., day, yr.) April 26 1910  
 8. AGE: Years 37 Months 9 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Waynesboro Franklin Co. Pa.  
 (Town, county, and state)  
 10. Usual occupation Clerk  
 11. Industry or business Victor Products Corp  
 12. Name Martin L. Wyand  
 13. Birthplace Keedysville Md.  
 14. Maiden name Jane Haverstick  
 15. Birthplace Waynesboro Pa.

16. Informant Mrs. Mary G. Wyand  
 Address Hagerstown Md.  
 17. Burial Date thereof 2/12/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.  
 19. Feb. 11. 19 48 Blackburn  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 19\_\_\_\_ al 3.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 to Feb. 9 and that I last saw him alive on Feb. 8 1948

Immediate cause of death Coronary occlusion  
Myocardial Infarction - Rupture  
 DURATION 12 hrs.  
12 hrs.

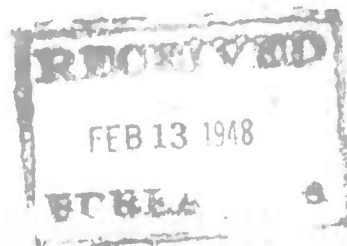
Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Philip J. Hirshman MD  
Hagerstown Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 2/9/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02108 302

### 1. PLACE OF DEATH:

County..... Washington  
City or town..... Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... Life  
Hospital, institution, or street address where death occurred:  
Prospect St Diner N Prospect St  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 408 W Washington St  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Albert Yingling

### 3. (b) Social Security Number

214-09-0615

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife..... 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... September 18, 1880

8. AGE: Years..... 67 Months..... 4 Days..... 24 It less than one day..... hrs. .... min.

9. Birthplace..... Hagerstown, Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation..... Janitor

11. Industry or business..... Leiter Brothers

12. Name..... Allen Yingling

13. Birthplace..... Hagerstown, Maryland

14. Maiden name..... Clara J. Fechtig

15. Birthplace..... Hagerstown, Maryland

16. Informant..... Mrs. Elizabeth Bembyr  
Address..... New York City

17. Burial..... Burial Date thereof..... Feb 13 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown Maryland

18. Funeral director..... C. M. Suter & Sons

Address..... Hagerstown, Maryland

19. Feb. 13. 19 48 Charles Powers  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 11/48 19..... at..... 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19..... and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

acute coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. Robert Wells DEPUTY MEDICAL EXAM.

Address..... Hagerstown, Md. WASH. CO. MD.

Date..... Feb 11 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



